CALIFORNIA MEDICAL PROTOCOL FOR EXAMINATION OF CHILD PHYSICAL ABUSE AND NEGLECT VICTIMS

State of California
Governor's Office of Emergency Services

Available at: **www.calema.ca.gov**

PREFACE

Pioneers in the field of child physical abuse and neglect began in the field of medicine. They were subsequently joined by the disciplines of social work, nursing, law enforcement, psychology, psychiatry, and child development.

The history of this intervention movement is characterized by peaks and plateaus as the larger community assimilated new developments lead by the pioneering disciplines. Medicine began the movement with published observations by a pediatric radiologist, Dr. John Caffey, in the 1940's. Dr. Henry Kempe, a pediatrician, galvanized the movement by establishing the concept of the "battered child syndrome" in 1962. He took his concerns to Congress and by 1965, most states had enacted child abuse reporting laws.

Issuance of the CalEMA 2-900 Medical Report for Suspected Child Physical Abuse and Neglect Examinations and Protocol takes the field to a new level. In 2002, the California Legislature and Governor declared that adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations. The Legislature enacted and the Governor signed SB 580, Statutes of 2002 (Figueroa), into law to address this need by establishing a standardized medical report form and protocol.

Many deserve recognition for the vision captured in these documents. The Children's Justice Act Task Force recommended the allocation of funds to accomplish this project; the Child Physical Abuse and Neglect Advisory Committee contributed wisdom, consultation, and guidance; and, the California Clinical Forensic Medical Training Center at the University of California, Davis is commended for strong work, expertise, and dedication to the production of the form, instructions, and protocol. This collective effort moves the field forward on behalf of children.

The California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect Victims provides recommended methods for meeting the minimum legal standards established by Penal Code Section 11171 for performing medical examinations of physically abused and neglected children. This protocol contains the following information:

- Standard medical report form (CalEMA 2-900) for documentation of findings from suspected child physical abuse and neglect examinations;
- Step-by-step procedures for conducting examinations opposite each page of the standard forms;
- Examination protocol for child physical abuse and neglect;
- Contextual information for performing examinations and implementing a multi-disciplinary team approach; and
- Relevant and expanded information on patient consent, mandatory reporting laws, financial compensation for examinations, crime victim compensation, and evidence collection and preservation.

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CHAPTER I

USE OF STANDARDIZED FORMS AND TRAINING

In 2002, the California Legislature enacted and the Governor signed SB 580 Statutes of 2002 (Figueroa) into law to amend the penal code pertaining to the performance of medical examinations for physically abused and neglected children. See **Appendix A** for a copy of this penal code section. The Legislature declared that:

- Adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations; and

- Enhancing examination procedures, documentation, and evidence collection relating to child abuse and neglect will improve the investigation of child abuse and neglect as well as other child protection efforts.

A. CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATIONS

As a result, the Governor's Office of Emergency Services issued effective January 1, 2004 the CalEMA 2-900 Medical Report: Suspected Child Physical Abuse and Neglect Examination for recording the results of medical examinations.

CalEMA 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18

B. CHILD SEXUAL ABUSE EXAMINATIONS

In 1984, the California Legislature enacted legislation to establish standardized procedures for the performance of child sexual abuse and sexual assault medical evidentiary examinations. California Penal Code Section 13823.5 requires the use of these standard forms for examinations of victims of child sexual abuse and adult and adolescent sexual assault.

Required Standard State Forms for Child Sexual Abuse and Sexual Assault Exams

CalEMA 923	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination**
CalEMA 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination**
CalEMA 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination**

Recommended Standard State Form

CalEMA 950	**Forensic Medical Report: Sexual Assault Suspect Examination**

Key terms for Sexual Assault and Child Sexual Abuse Examinations

These terms are used to describe time frames. They are not intended to suggest that, after 72 hours, a complete examination should not be done. It is not uncommon to detect physical findings after 72 hours.

Acute	**Less than 72 hours have passed since the incident (<72 hours)**
Nonacute	**More than 72 hours have passed since the incident (>72 hours)**

C. SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

CalEMA 923	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination** • History of **acute sexual assault** (<72 hours) • Examination of adults (age 18 and over) and adolescents (ages 12-17)
CalEMA 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual abuse** (>72 hours) • Examination of children and adolescents under age 18
CalEMA 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination** • History of **chronic sexual abuse (incest) and recent incident** (<72 hours) • Examination of children and adolescents under age 18
CalEMA 950	**Forensic Medical Report: Sexual Assault Suspect Examination** • Examination of person(s) suspected of sexual assault or child sexual abuse

D. TRAINING

The California Clinical Forensic Medical Training Center (CCFMTC) was established by Penal Code Section 13823.93 and is grant funded to provide training for physicians and nurses on how to perform medical evidentiary examinations for victims of:

- Child physical abuse and neglect;
- Child sexual abuse;
- Sexual assault;
- Domestic violence; and
- Elder and dependent adult abuse and neglect.

Training is also provided to criminal justice and investigative social services personnel on the interpretation of medical findings for use in case investigations, prosecution, and for others involved in the evaluation of medical evidence. See **Appendix B** for information on how to contact the California Clinical Forensic Medical Training Center at the University of California, Davis.

The California Clinical Forensic Medical Training Center at the University of California, Davis developed the CalEMA 2-900 form, instructions and examination protocol under an additional grant from the Governor's Office of Criminal Justice Planning (now the California Emergency Management Agency).

CHAPTER II

MANDATORY REPORTING AND CONFIDENTIALITY OF REPORTS

A. MANDATORY REPORTING

The Child Abuse and Neglect Reporting Act is contained in Penal Code Section 11164-11174.4. The intent and purpose of the mandatory reporting law is to protect children from abuse and neglect. As used in this section, a child means a person under the age of 18.

1. Health practitioners are mandated reporters

There are 35 categories of professionals, paraprofessionals and employees of institutions, organizations, and commercial film and photographic print processing companies required to report suspected child abuse and neglect pursuant to Penal Code Section 11165.7. See **Appendix C** for a list of these categories.

Health practitioners are required to report known or suspected child abuse and neglect **immediately by telephone and to submit a written report within 36 hours** to a child protective agency.

- A health practitioner means a physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code (Penal Code Section 11165.7).

- Related categories include emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a coroner, and a medical examiner.

- A child protective agency means a law enforcement agency, the county department of social services, or the county probation department.

- The obligation of mandated reporters to make a report to a child protective agency arises when they, in their professional capacity or within the scope of their employment, have knowledge of or observe a child who they know or reasonably suspect has been the victim of child abuse (Penal Code Section 11166).

- The term “reasonable suspicion” means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate, on his or her training and

experience, to suspect child abuse and neglect. For the purpose of this article, the pregnancy of a minor does not, in and of itself, constitute a reason for a reasonable suspicion of child sexual abuse (Penal Code Section 11166).

- For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself, a sufficient basis for reporting child abuse and neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department, and not to a law enforcement agency (Penal Code Section 11165.3).

- No supervisor or administrator may impede or inhibit these reporting duties and no person making such a report shall be subject to any sanction for making the report (Penal Code Section 11166).

2. Criminal penalties for failure to report child abuse or neglect

The failure of a mandated reporter to report known or suspected child abuse or neglect is punishable by a fine not to exceed $1,000, by imprisonment in the county jail for a period not to exceed six months, or both (Penal Code Section 11166).

3. Telephone and written report requirements (Penal Code Sections 11165-11168)

- Make an immediate telephone report to a child protective agency and include the following information:
  - Name of the person making the report;
  - Name of the child;
  - Present location of the child;
  - Nature and extent of the injury; and
  - Other information requested by the child protective agency.

- Submit a written report to a child protective agency within 36 hours, using the Suspected Child Abuse Report Form (DOJ SS 8572). See **Appendix D** for a copy of this form. See **Appendix E** for a list of Child Protective Services (CPS) agencies for every county in California to obtain information and training on the use of the form.

- When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the

team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report (Penal Code Section 11166).

4. Immunity from civil or criminal liability for complying with the child abuse reporting law

- Health practitioners and others required to report known or suspected child abuse cannot be held civilly or criminally liable for any report required or authorized by the child abuse reporting law (Penal Code Section 11172).

- Physicians and hospitals may be held liable for injuries sustained by a child for failure to diagnose and report child abuse to authorities resulting in the child being returned to the parents and receiving further injuries by them (Landeros v. Flood, (1926) 131 CAL. RPTER 69, 551 P.2d 389, 17 C.3d 399, 97 A.L.R. 3d 324).

5. Definitions of unfounded, substantiated, and inconclusive reports used by child protective agencies (Penal Code Section 11165.12)

Unfounded Report
Unfounded report means a report that is determined by the investigator who conducted the investigation to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse or neglect, as defined in Penal Code Section 11165.6.

Substantiated Report
Substantiated report means a report that is determined by the investigator who conducted the investigation, based upon some credible evidence, to constitute child abuse or neglect, as defined in Penal Code Section 11165.6.

Inconclusive Report
Inconclusive report means a report that is determined by the investigator who conducted the investigation not to be unfounded, but one in which the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect, as defined in Section 11165.6, has occurred.

B. CONFIDENTIALITY OF REPORTS

1. Confidentiality of suspected child abuse and neglect report forms
Written reports required by the child abuse reporting law are confidential and can only be released to agencies receiving or investigating mandated reports (law enforcement or child protective services); to the district attorney involved in a

criminal prosecution; counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code; county counsel; a county or state licensing agency when abuse or neglect in out-of-home care is reasonably suspected; coroners; medical examiners; and multi-disciplinary personnel teams as defined in Section 18951 of the Welfare and Institutions Code; Hospital SCAN Teams; and other specified institutional entities (Penal Code Section 11167.5). Any violation of confidentiality is punishable by up to six months in jail, by a fine of $500, or both (Penal Code Section 11167.5).

- **Multi-disciplinary Team**
  Multi-disciplinary personnel, defined in Welfare and Institutions Code Section 18951, means any team of three or more persons who are trained in the prevention, identification, and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse.

  The team may include, but not be limited to:
  - Psychiatrists, psychologists, or other trained counseling personnel;
  - Police officers or other law enforcement agents;
  - Medical personnel with sufficient training to provide health services;
  - Social workers with experience or training in child abuse prevention; and
  - Any public or private school teacher, administrative officer, supervisor of child welfare attendance, or certified pupil personnel employee.

- **Hospital SCAN Team**
  A hospital SCAN (Suspected Child Abuse and Neglect) team means a team of three or more persons established by a hospital, or two or more hospitals in the same county, consisting of health care professionals and representatives of law enforcement and child protective services, the members of which are engaged in the identification of child abuse or neglect. The disclosure authorized by this section includes disclosure among all hospital SCAN teams (Penal Code Section 11167.5).

2. **Release of medical reports of suspected child abuse and neglect**
   Medical report(s) are subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code 11164-11174.4 or privilege), the Medical Information Act (Civil Code Section 58 et seq.), the Physician-Patient Privilege (Evidence Code Section 990), and the Official Information Privilege (Evidence Code Section 1040). They can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services social worker, a child abuse and neglect multi-disciplinary team member, county licensing agency, and coroner. Medical reports can only be released to the defense counsel through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

CHAPTER III

CONSENT ISSUES

A. CHILDREN/MINORS

1. Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat, or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g., law enforcement agency or child protection services) to perform the examination. Follow local policy regarding placement of children in protective custody.

2. Photographs of injuries

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents and by their direction may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child-victim the costs incurred by the county for the x-ray.

No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

B. MINORS DEFINED BY STATUTE AS 12 YEARS OF AGE OR OLDER

1. Consent to medical treatment

- Minors may give consent to the provision of medical care related to the diagnosis or treatment of a sexual assault and the collection of evidence (Family Code Sections 6927 and 6928).
- Minors may give consent to the provision of medical care related to the prevention or treatment of pregnancy (Family Code Section 6925).
- Minors may give consent to the provision of medical care related to the diagnosis or treatment of sexually transmitted diseases (Family Code Section 6926).
- Consent given by a minor is not subject to disaffirmance because of minority (Family Code Section 6921).

2. Consent to mental health treatment, residential shelter services, or drug and alcohol counseling services

- Minors may consent to mental health treatment, counseling on an out-patient basis or residential shelter services if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services; the minor would present danger of serious physical or mental health harm to self or to others without the mental health treatment or counseling or residential treatment services; or, is the alleged victim of incest or child abuse (Family Code Section 6924).
- Minors may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem (Family Code Section 6929).

CHAPTER IV

REIMBURSEMENT FOR EXAMINATIONS

A. CHILD PHYSICAL ABUSE AND NEGLECT MEDICAL EXAMINATION REIMBURSEMENTS

In the majority of counties in California, charges for child physical abuse and neglect examinations are billed to Medi-Cal or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of charges may be obtained through California Victim Compensation and Government Claims Board. See Chapter V Crime Victim Compensation and Victim Assistance Programs.

Some counties have contracts with private hospitals for various medical services (e.g., indigent care) and include a provision for payment of these examinations if there is no public or private insurance reimbursement. Follow local policy.

A direction for the future to support the development of local medical experts in the evaluation of child physical abuse and neglect examinations is to develop a fee structure for rendering an expert opinion.

B. CHILD SEXUAL ABUSE AND SEXUAL ASSAULT MEDICAL EVIDENTIARY EXAMINATION REIMBURSEMENTS (PENAL CODE SECTION 13823.95)

No costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the examination of a victim of a sexual assault or child sexual abuse, as described in the protocol developed pursuant to Penal Code Section 13823.5, when the examination is performed, pursuant to Sections 13823.5 and 13823.7, for the purposes of gathering evidence for possible prosecution, shall be charged directly or indirectly to the victim of the assault. These costs shall be treated as local costs and charged to the local governmental agency in whose jurisdiction the alleged offense was committed.

Charges for the forensic medical examination, not medical treatment, shall be submitted to the law enforcement agency requesting the examination. See California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims published by the Governor's Office of Emergency Services (www.calema.ca.gov).

CHAPTER V

CRIME VICTIM COMPENSATION AND VICTIM ASSISTANCE PROGRAMS

A. VICTIM COMPENSATION PROGRAM (VCP)

The Victim Compensation Program (VCP) can help victims of violent crime and their families deal with the emotional, physical, and financial aftermath of crime. Victims can apply for compensation by filing an application with the California Victim Compensation and Government Claims Board, which administers VCP.

1. Eligibility

- A California resident or out-of-state resident injured in California who suffers physical injury and/or threat of physical injury, or death. Victims of sexual assault and child sexual abuse are presumed to have suffered physical injury;
- A person who is physically injured or threatened with physical injury as a result of a crime or act of terrorism that occurred in the State of California;
- A California resident or member of the military stationed in California who is a victim of a qualifying crime, wherever it occurs;
- An eligible family member or other specified persons who were legally dependent on the victim;
- A parent, sibling, spouse, or child of the victim;
- The fiancé(e) of the victim at the time of the crime or another family member of the victim who witnessed the crime;
- A grandparent or grandchild of the victim at the time of the crime, or a person living with the victim at the time of the crime, or who had previously lived with the victim for at least two years in a relationship similar to a parent, grandparent, spouse, sibling, child, or grandchild of the victim;
- A minor who witnesses a crime of domestic violence or who resides in a home where domestic violence occurs;
- Anyone who pays or assumes legal liability for a deceased victim's medical, funeral, or burial expenses, or anyone who pays for the costs of crime scene clean-up for a homicide that occurred in a residence; and
- A person who is the primary caretaker of a minor victim when treatment is rendered.

2. Expenses that are eligible for reimbursement

- Medical and medical-related expenses for the victim, including dental expenses;
- Outpatient mental health treatment or counseling;
- Inpatient psychiatric hospitalization costs under dire or exceptional circumstances;
- Funeral and burial expenses;

- Wage or income loss;
- Loss of financial support for legal dependents of a deceased or injured victim;
- Job retraining expenses;
- Relocation expenses up to $1000 per household;
- Home security installation or improvements up to $1000, if the crime occurred in the victim's home;
- Crime scene clean-up to $1000, if the victim dies as a result of a crime in the residence; and
- Medically necessary renovation or retrofitting of a home or vehicle for a person permanently disabled as a result of the crime.

3. Reimbursable expenses

For crimes that occurred prior to January 1, 2001, the maximum amount that can be reimbursed is $46,000. For crimes that occurred after January 1, 2001, the maximum amount that can be reimbursed is $70,000. Expenses for psychological counseling are also reimbursable, but are generally limited to 40 sessions. Additional sessions may be authorized upon request.

4. Examples of eligible victims

- Child physical abuse victims
- Child sexual abuse victims
- Child endangerment or abandonment
- Domestic violence victims (e.g. spouses, cohabitants) including children in domestic violence households
- Stalking
- Elder and dependent adult abuse victims
- Sexual assault victims
- Survivors of homicide victims
- Assault and battery victims
- Robbery victims
- Hit and run victims
- Victims of acts of terrorism
- Victims of drivers under the influence of drugs and/or alcohol

5. Definition of a victim, injury, and derivative victims

- A victim is defined as a person who suffers injury or death as a direct result of a crime.

- An injury means either a physical injury or an emotional injury if the victim also suffered physical injury or threat of physical injury. Specified victims, including child victims of neglect and of most sex crimes, are presumed to have sustained physical injury.

- A derivative victim is defined as a person who has any of the following characteristics:

- ➢ At the time of the crime was the parent, grandparent, sibling, spouse, or child/grandchild of the victim;
- ➢ At the time of the crime was living in the household of the victim;
- ➢ A person who has previously lived in the household of the victim for a period of not less than two years in a relationship substantially similar to that of a parent, sibling, spouse, or child of the victim; or,
- ➢ A family member of the victim, including the victim's fiancé, and who witnessed the crime.

6. Requirements

- The crime must be reported to a law enforcement agency or to Child or Adult Protective Services. In some domestic violence cases, a restraining order may suffice.

- The victim must cooperate with law enforcement in the investigation and prosecution of any known suspect(s). If the victim is a child who has been confirmed as abused, the child may qualify with or without the child's legal guardian's cooperation with the authorities, or the identification or prosecution of any known suspects.

- The victim must not have knowingly and willingly participated in the commission of the crime or engaged in conduct that causes or leads to the crime. This provision does not apply to children.

- Victims (18 years or older at the time of the crime) must file an application with the State Victim Compensation Program within one year from the date of the crime. Victims (under 18 years of age at the time of the crime) must file the application before their 19th birthday. Late claims may be accepted if "good cause" is provided.

- Eligibility for program benefits will be limited if the victim/claimant was convicted of a felony committed on or after January 1, 1989, and has not been discharged from probation, parole, or released form a correctional institution at the time of the incident (Government Code Section 13956 (d)).

7. Responsibilities of hospitals

- **Display posters in the emergency room**
  Licensed hospitals in the state of California must prominently display posters in the Emergency Department notifying crime victims of the availability of victim compensation and the existence and location of the local county victim/witness assistance center (Government Code Section 13962).
- **Provision of crime victim compensation claim forms**
  County hospitals must provide Application for Crime Victim Compensation forms to sexual assault victims (Health and Safety Code Section 1492).

8. Application for compensation

Information on crime victim compensation can be obtained by contacting local county victim/witness assistance centers or the State Victim Compensation Program administered by the Victim Compensation and Government Claims Board (www.boc.ca.gov/victims.htm). Local county victim/witness assistance centers provide assistance to victims in the preparation and submission of these applications for compensation.

Claims can also be submitted directly to the State by completing an application form and mailing it to:

Victim Compensation Program
P.O. Box 3036
Sacramento, CA 95812

The application can be completed online at www.boc.ca.gov/victims.htm. Directions are provided on the website.

Victims may also be assisted by a private attorney in filing claims. California Government Code Section 13957.7(g) provides that the Board shall pay private attorney fees of 10 percent of the approved award up to a maximum of $500, and these fees are not deducted from the applicant's award.

9. Limitations

The Victim Compensation Program (VCP) is the "payer of last resort." Other sources of reimbursement such as health or disability insurance must be used first.

B. VICTIM ASSISTANCE PROGRAMS

County victim/witness assistance centers, child abuse treatment programs, domestic violence shelters, and special crime victim counseling centers exist in California to provide counseling and other forms of assistance to crime victims. Contact the county victim/witness assistance center for information on local resources. See **Appendix F** for a list of victim/witness assistance centers. Or, call the State Victim Compensation Program at 1-800-777-9229 or 1-800-735-2929 for the hearing impaired.

CHAPTER VI

KNOWLEDGE AND SKILLS NEEDED BY MEDICAL PERSONNEL IN THE PERFORMANCE OF EXAMINATIONS

A. KNOWLEDGE

Medical personnel performing medical examinations of physically abused and neglected children should be knowledgeable about:

- Health professionals' responsibilities as "mandated reporters";
- Roles of law enforcement, child protective services, county counsel, deputy district attorneys, crime laboratories, attorneys appointed for court dependent children, and CASA (Court Appointed Special Advocates);
- Importance of scene investigation by law enforcement, particularly in the forensic evaluation of burn injuries;
- Epidemiology and clinical presentations of common accidental injuries in children;
- Pathophysiology of traumatic injury to the cutaneous, skeletal, visceral, central nervous system, and ocular areas of children;
- Injuries to children that are highly specific for physical abuse;
- Medical conditions and accidental injuries that can mimic physical abuse injuries;
- Types of child neglect, clinical presentation, and differential diagnosis;
- Differential diagnosis of failure to thrive;
- Role of radiology in the evaluation of physically abused children;
- Role of laboratory tests in the evaluation of injuries that may represent abuse;
- Role of pediatric subspecialists in the evaluation of children alleged to have been abused; and
- Role of the juvenile or family, and superior court system.

B. SKILLS

Medical personnel must be able to:

- Take a complete history from a parent or guardian about the circumstances of the child's injury, past medical conditions, and birth history;
- Perform a detailed and careful physical examination of an infant, child, or adolescent;
- Document cutaneous injuries clearly in writing and by proper use of photographic equipment;
- Make an assessment of the injury as to the likelihood of abuse based upon the history, physical examination, and laboratory and radiologic evaluation;
- Make an assessment of child neglect;
- Communicate clearly and in lay terms with non-medical personnel about the medical findings;
- Communicate in a non-adversarial manner with parents and/or guardian about the responsibilities of medical professionals to report suspected child abuse; and
- Testify in court as to one's objective findings and assessment of injuries.

CHAPTER VII

EXAMINATION PROTOCOL: CHILD PHYSICAL ABUSE

A. STEP ONE: RECOGNIZE A PATIENT HISTORY THAT DOES NOT MATCH FINDINGS

1. Patient history patterns suggestive of possible child maltreatment

- No explanatory history for significant trauma or trauma in a highly supervised age.
- Inconsistent history given:
  - History fails to explain the nature, severity, or pattern of the injury;
  - History of the logistics or mechanics of the injury do not match the injury;
  - History of minor or common trauma to explain severe or unusual injuries;
  - History describes child actions that are inconsistent with developmental abilities;
  - History blames or suggests a third party; and
  - Injuries are indicative of an object (e.g. belt buckle not included in history).
- History changes with retelling or provider probing.
- History blames the child for injuring himself or herself.
- History blames another child for causing the injury.
- History suggests neglect and/or lack of supervision.

2. Patient history with discrepancies

Care providers falsify histories to protect themselves and others from culpability associated with the true events. When health practitioners point out the inconsistency of the given or absent history, care providers may alter their story in an attempt to satisfy the practitioner. When detailed histories are taken from two historians, or at different times, discrepancies may appear as on-the-spot falsification of events occurs. Discrepancies that cannot be resolved are a strong indication of falsification and the culpability it implies.

B. STEP TWO: RECOGNIZE MEDICAL EVIDENCE OF POSSIBLE PHYSICAL ABUSE

Physical abuse is characterized by inflicting physical injury by slapping, hitting, punching, beating, kicking, throwing, biting, burning, or otherwise physically harming a child. The injury may be the result of a single episode or of repeated episodes. The physical trauma can range in severity from minor bruising, abrasions, lacerations, burns, eye injuries, and fractures to damage to the brain and internal organs (liver, spleen, abdomen, pancreas, and kidneys). Head and internal injuries are the leading causes of child

abuse-related deaths. This form of abuse also includes extreme forms of punishment such as torture or confinement of children in dark closets, boxes, or rooms for days, months, or even years at a time.

1. **Cutaneous patterns suggestive of possible child maltreatment**
   - Bruises or burns shaped like recognizable objects;
   - Repeated but unrecognizable patterned bruises or burns;
   - Bruises in children who are not pulling themselves up, and walking along furniture;
   - Buttock bruises in children wearing diapers;
   - Two or more facial bruises without clear explanation;
   - "High tide mark" burn distribution;
   - Symmetrical lesions;
   - Burns with no evidence of motion effect;
   - Evidence of untreated healing fractures; and
   - New fractures on old.

2. **Skeletal injuries suggestive of possible child maltreatment**
   - Rib fractures in young children, particularly when posterior;
   - Metaphyseal corner fractures;
   - Fractures in infants other than simple skull and clavicle fractures;
   - High energy fractures without serious accidents (e.g., long distance fall, MVA); and
   - Multiple fracture sites without serious accidents (e.g., long distance fall, MVA).

3. **Signs and symptoms of dentofacial trauma**
   - Avulsed teeth;
   - Lip lacerations;
   - Tongue injuries;
   - Frenulum injuries; and
   - Jaw and facial fractures.

4. **Syndromes of possible child maltreatment**
   - **Battered Child Syndrome**
     - Multiple distinct injuries, separated by time or cause; and
     - Inadequate explanation by disease, accident, or typical childhood injury.
   - **Shaken Baby Syndrome also called Abusive Head Trauma**
     - Intra-cranial injury;
     - Absence of verified severe trauma (e.g., MVA, long distance fall);
     - Additional findings of rib fracture, metaphyseal fractures, other injuries; and
     - Retinal hemorrhages.

Syndromes are patterns of associated findings, which suggest an etiology. Two syndromes have become well established in the abuse literature. The **Battered Child**

Syndrome can be defined as the presence of multiple separate injuries with inadequate explanation. The injuries must be distinct enough in age, location and mechanism, so that they were separately caused. Explanation by disease state, adequate history of accidental injury, and typical events of childhood, must be excluded. Once these conditions are met, inflicted injury is the most likely cause. The concept of multiple injuries in time and space is included in discussions of many of the specific abuse entities, and is a basic principle with high predictive value in child abuse. Once the whole story is known, this theme is seen again in the abuser's tendency to use violence on multiple family members, and even family pets. For many abusers, violence or losing control is a habit identified in child abuse cases.

The other major syndrome of child abuse is the **Shaken Baby Syndrome also called Abusive Head Trauma**. Originally described as the co-occurrence of long bone fractures and sub-dural hematoma, it is now known that fractures of the ribs or metaphyses are present about half of the time, and retinal hemorrhages are present about eighty percent of the time. The finding of retinal hemorrhages has been particularly well studied, and almost always signifies child abuse. Due to controversies in understanding the basic mechanism of injury, many authors now simply refer to Abusive Head Trauma. Identifying abusive head trauma rests on another basic principle of child abuse. The presence of intra-cranial traumatic injury, without a history of severe trauma identifies probable abuse. This principle of severe injury with trivial history has been noted in fractures, and is also found in abdominal and other internal injuries.

5. Disclosure and findings associated with child sexual abuse

- Child discloses sexual abuse;
- Sexually obsessive, aggressive or coercive behavior;
- Sexually transmitted diseases;
- Acute anogenital injuries without clear accidental cause; and
- Absence or interruption of the posterior hymen.

For further discussion, consult the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims available at www.calema.ca.gov.

6. Other findings suggestive of possible child maltreatment

- Child does not gain weight as expected;
- Child's development and behavior is disturbed;
- Child has too many accidents;
- Illnesses are more severe or prolonged than expected;
- Illnesses defy diagnosis;
- Medical treatments are not effective;
- Illnesses are found to be due to poisoning or occult trauma; and
- Accidental or non-accidental illicit drug ingestion.

C. STEP THREE: EVALUATE THE CHILD FOR POSSIBLE ABUSE

1. **Obtain history from the patient (separately if possible) and caregivers**
   - **Extensively probe the history of explanatory events**
     - Do not accept absent history;
     - Challenge inadequate histories;
     - Note changes in history and when they occur; and
     - Push for details consistent with the apparent mechanism of injury.
   - **Conduct review of systems**
     - Evaluate medical history suggesting alternate diagnoses;
     - Evaluate medical history of significant concurrent illness; and
     - Obtain information on immunization and developmental status.

2. **Perform comprehensive physical examination**
   - **Record height and weight, and plot against age-based norms. For children under age two, record head circumference and percentile.**
   - **Assess developmental abilities, particularly speech**
   - **Perform multisystem total body exam**
   - **Give special scrutiny to important abuse areas**
     - Scalp;
     - Behind ears, in folds of pinna, and along top edge of pinna;
     - Mouth, labial and lingual frenula, tonsillar pillars, posterior pharynx; and
     - Palms of hands and soles of feet.
   - **Perform genital exam**
     - Traction of labia majora; and
     - Knee chest exam.

3. **Request ancillary studies, if indicated**
   - **Radiology**
     - Skeletal survey on children less than two; and
     - CT scan of the head for abused children with any neurologic signs.
   - **Laboratory**
     - CBC, PT, PTT, bleeding time for abusive bruises; and
     - Urinalysis, amylase and transaminases for occult abdominal injury.
   - **Consultative examinations**
     - Indirect ophthalmoscopy for any suspicion of Shaken Baby Syndrome also known as Abusive Head Trauma.

4. **Obtain a history from the child and caregiver**

   - **Obtain history from the child, if verbal; and separate from the caregiver, if possible.**
     If the child is verbal, the medical practitioner should take the history separate from the caregiver, if possible. The child may be able to tell the practitioner the true history, or may produce significant inconsistencies to protect the caregiver, which should be noted. Other reasons exist to speak with the child. Many children from abusive and neglectful homes are developmentally delayed. Careful listening to the child's speech, and general questioning about their life may lead to diagnoses of developmental delay, depression, or anxiety.

   - **Obtain history from caregiver.**
     When an injured child presents with a responsible care provider, the practitioner must take the opportunity to request an explanation of the injuries. Bruises on young infants, and patterned bruises on older children should not be bypassed without comment or question. In most cases of abuse, diagnosis rests with the lack of adequate explanatory history. Careful, persistent questioning, pursuing areas of apparent inconsistency, may produce a true abuse disclosure, or serve to further demonstrate the inconsistency. On the other hand, failure to accept the initial, inconsistent history, may force the caretaker to reveal details of an unusual accident, which they were too embarrassed, upset, or confused to disclose when questioned. When the practitioner has a strong sense of how the injuries occurred, he or she may choose to reveal this in questioning. Before doing so, it is important to carefully note the caretaker's first response, as abusers may incorporate your suggestions into their defensive falsehoods. Documenting this changing history may become important in identifying child abuse. Similarly, the medical practitioner must take a history that probes for possible exonerating differential diagnoses. It is best that these questions be asked neutrally, and answers examined critically, so as to avoid providing an excuse for the guilty, or missing innocent explanations. The format of a traditional review of systems and family history is excellent in that it is familiar to practitioners, seeks all information pertinent to the care of the child, and reviews a wide range of information, the significance of which may only be grasped later.

5. **Perform a comprehensive medical examination**
   Perform a comprehensive "head-to-toe" medical examination. Certain elements of the examination take on particular importance in the setting of possible child abuse. As the most common target for abusive injury, all surfaces of the skin deserve special scrutiny. The scalp is often difficult to see due to long or dense hair. Contusions, lacerations, scars or even tattoos may be hidden by hair. The external ears are often overlooked. Looking behind the ears may reveal fingernail marks

or other injuries. Small subtle bruises may be found within the folds or along the top of the pinna, which are strong evidence of abusively striking or pulling the ears. Other less commonly seen surfaces of the skin, including the perineum and bottoms of the feet should be viewed, searching for injuries.

- **Areas of injury**
  Special attention should be paid to areas of injury. Providers should carefully look at injuries for pattern or shape, evidence of healing or delayed care seeking, and possible alternate explanation. Red marks should be pressed or stretched to see if they blanche, in order to distinguish vascular markings from bruises. Follow up examination may be required to completely evaluate skin findings. Fresh bruises often become more prominent. Injuries such as bruises and lacerations are expected to heal over a predictable period of time. Following them through healing may help to distinguish trauma from other findings such as nevi, vascular lesions, and “mongolian” spots. All injuries should be measured, described, drawn, and, where possible, photographed with a size standard in the photo. Use a 35mm or a digital camera. Follow local policy. See Chapter X Photography.

- **Head, eyes, and mouth**
  Other structures of the head should be examined more closely than in typical well child checks. Petechiae of the conjunctiva are seen both with direct trauma, and with strangulation or suffocation. Retinal hemorrhages are sometimes seen during direct ophthalmoscopy, and are significant both as signs of abuse, and probable neurologic injury. The mouth requires careful attention. Bruises, lacerations or impressions inside the lips may occur when a child is struck in the face. Tearing of the labial or lingual frenula may occur during blows to the mouth, or forced feeding. Lacerations of the posterior pharynx have also occurred during forced feeding, and may result in serious medical complication. The abdomen and head are the most common sites for severe and fatal injuries to children. The examiner must be certain that the belly is benign, and the child’s neurological status is clear.

- **Musculoskeletal system**
  The musculoskeletal system, as another commonly injured system, also receives greater scrutiny than in typical general physical exams. Observe the child for deformity. See if a limb is favored, or seems painful. The chest and extremities should be palpated, feeling for tenderness, mass, or crepitance. Any signs of possible trauma require examination in greater detail, and radiological assessment.

A skeletal survey is recommended when evaluating possibly abused children below age two. Unfortunately, as suggested previously, child abuse is an event that is likely to be repeated, with children held back from medical attention. Skeletal injuries may be clinically inapparent because they have begun to heal. Many fractures found in child abuse settings are clinically unexpected. Inexperienced facilities may obtain whole body views or “baby grams” when a skeletal survey is requested. This is inadequate. Properly posed and exposed views of the ribs, spine, head, upper extremities, lower extremities, hands and feet are required. Two views of the ankles, knees, shoulders and elbow, will help to detect metaphyseal fractures. When rib fractures are suspected, oblique views may help to detect them.

- **Genitals and anus**
  Putting the child on his or her knees, with the buttocks in the air, chest on the table, and back in a lordotic posture makes this examination much easier. Evaluation of the anus and genitals may require special techniques, which are easily learned by general medical examiners. Separation of the buttocks in this posture gives a clear view of the anus. Lifting and separating the buttocks exposes the female genitalia giving the best view for evaluating the hymen. Female genitalia may also be evaluated with the child on her back with the legs abducted and externally rotated. Grasping and drawing outward on the labia majora will open the vestibule and vaginal orifice for better inspection.

- **Laboratory testing**
  Laboratory testing is ordered based on the practitioner’s assessment of the child. A complete blood count will screen for anemia, which is commonly found in neglected children. The platelet count will also help to rule out causes of easy bleeding. A prothrombin and partial thromboplastin time, and possibly a Von Willebrand’s Panel will complete this screen in children with bruises. If there is suspicion of abdominal trauma, but the patient does not appear to require imaging or surgery, urinalysis, amylase and liver transaminases will increase the likelihood of detecting milder internal injuries. Children who have neurologic injury, and those with rib or metaphyseal fractures, should have a dilated indirect ophthalmoscopy exam. Direct ophthalmoscopy, even with dilation, is inadequate to completely rule out retinal hemorrhages. Any child with signs of abuse, such as facial bruises, and even mild neurologic signs, such as vomiting without diarrhea, irritability or somnolence deserves a CT scan of the head. Milder forms of abusive head injury have been overlooked, and children returned with complications from the delay, in similar situations.

- **Screen for developmental, behavioral, and emotional problems**
  The physical examination of an abused or neglected child must evaluate all body systems. A high percentage of abused and neglected children have been found to have medical problems. A good well child examination serves as the basis for a sound child maltreatment evaluation. Such an examination begins with a developmental assessment. The behavioral, mental, and physical development should be compared against age based norms. A Denver Developmental Screening Test (DDST) or similar developmental inventory will begin to screen for delays in language and motor development. An experienced practitioner will have an experience with similar aged children, and should comment on important departures in the child's behavior. Accurate height, weight, and head circumference must be obtained and plotted on appropriate growth charts. Small children may be further evaluated by having a body mass index, or weight for height checked. Single points in developmentally or growth delayed children are of limited value. When the initial assessment is concerning, follow up evaluation and more in depth assessment will be necessary.

6. **Report suspected child abuse and neglect and refer for consultation**
   Once the medical practitioner has completed the evaluation, the decision must be made if there is reasonable suspicion of child maltreatment. Many practitioners feel that they must prove abuse prior to reporting. This is not true. The legal statute for mandated reporters in the state of California requires a report for a reasonable suspicion of abuse or neglect. If the practitioner has a genuine concern for child maltreatment, and has not eliminated it through their own evaluation, an immediate telephone report must be made to the county children's protective services, or local law enforcement agency, and a written report filed within 36 hours. If a practitioner recognizes one of the medical findings detailed above, and fails to find a reasonable explanation, suspicion is reasonable regardless of the social circumstances and reporting should occur.

   A report is not treated as proof of abuse. The appropriate agencies will investigate the family situation, often finding important information of which the practitioner is not aware. The investigation may request more medical information from the practitioner, or consult a medical child abuse expert. Sometimes cases are unsubstantiated, because the investigation finds other explanatory evidence, or cannot adequately establish that abuse has occurred.

   Practitioners sometimes fail to report cases of child maltreatment. Usually, this is because they have failed to acknowledge the possibility, missed medical signs, or consciously chosen to set aside concerns of abuse. Child abuse experts at tertiary medical centers are usually willing to discuss cases by phone, or take direct referrals to help resolve these difficult cases. It is helpful to consider the legally required telephone and written report as a mandatory consultation.

Whether the practitioner makes a report of a suspicious situation, or refers the patient to a medical expert, addressing the reporting issue is central to providing adequate medical care for these children. Approximately 70% of children dying from abusive injuries have evidence of earlier abuse that could have been detected, possibly saving the child's life. By acknowledging the possibility of abuse, recognizing medical evidence, thoroughly evaluating, and then reporting suspicions, medical practitioners can fulfill their obligation to the state and the children they serve.

This chapter is a condensed version of the article entitled "Abuse, Detection, and Screening" by Stephen Boos, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER VIII

EXAMINATION PROTOCOL: CHILD NEGLECT

A. EVALUATION OF CHILD NEGLECT

1. **Obtain a complete medical history in children presenting with any condition suspected of being the result of neglect**
   - Obtain the birth history and weight at birth.
   - Ask whether the mother received prenatal care.
   - What immunizations has the child had?
   - Has the child received the appropriate health care over his/her lifetime?
   - Does the child have a primary care provider?
   - What is the baby's diet? Does the family have sufficient resources to meet everyone's nutritional needs? Do they receive food stamps? How often does the family skip a meal because of inadequate resources?
   - Obtain a history of developmental milestones.
   - Obtain information about schooling and school attendance. How often have children missed school during the previous six months? What school do they attend and what is their school performance?
   - Where does the family live? Who else lives in the household?
   - Obtain a social history, including economic resources, educational level of parents, substance abuse and incarceration. Who cares for the child when the parents are not available? Is extended family available?

2. **Perform a complete physical examination**
   - Weigh and measure the child, and plot measurements for gender and age on appropriate growth curves. When possible, review all prior growth parameters to determine whether growth impairment, if present, has been chronic or is of recent onset.
   - Assess nutrition and hygiene. Evidence of substandard nutrition can be noted on physical examination in the form of diminished subcutaneous tissue.
   - Assess bruises, scars, untreated injuries. Neglected children are at increased risk of physical abuse and for accidental injuries because of a general lack of supervision.
   - Screen for sexual abuse. Neglected and homeless children are at risk for sexual victimization.
   - Assess hygiene and absence of appropriate clothing (e.g. , cleanliness, smelling of urine or stool, or lack of shoes and clothing).

- Assess healthcare history.
  - Has there been lack of care for accidental injuries?
  - If there is a chronic medical condition, has there been treatment?
  - What are physical findings relevant to the condition?
- Review immunizations to ascertain whether the child is up to date. Depending upon the circumstances of the case, records may need to be obtained from schools, other hospitals and clinics, the local CHDP (Child Health, Disability, and Prevention Program), or the CWS/CMS system (a computerized database for managing information about children in the California child welfare system).
- Note clingy, aggressive, or overly-compliant behavior when experiencing painful procedures.

3. **Screen for dental problems**
   Unattended dental cavities are frequently present in neglected children. Signs and symptoms of dental neglect include untreated, rampant cavities; untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.

4. **Screen for developmental problems (e.g., motor skills, speech and language delay)**
   This screening should include the following areas: developmental milestones and history, sensorymotor abilities, speech and language acquisition, fine and gross motor skills, socio-emotional functioning, and adapative skills (e.g., eating patterns, sleeping, etc.).

5. **Order laboratory testing, if indicated**
   Laboratory tests should be ordered to diagnose and evaluate untreated and/or chronic medical conditions and to ascertain whether there are conditions which may be mistaken for neglect. In general, a hemoglobin is an appropriate study to obtain to determine if the child is anemic. Obtaining lead levels for children under six years of age is recommended.

6. **Order imaging studies, if indicated**
   Skeletal trauma series are indicated in children under the age of two years who have signs of severe neglect. The purpose of these studies is to detect the presence of occult fractures.

   Additional imaging studies are rarely needed in the assessment of the child who has been physically neglected unless there is some underlying medical condition that warrants such an evaluation. For instance, the child with recurrent urinary tract infections who has not been given the prophylactic antibiotics might need a renal scan to determine the extent of renal scarring that has developed.

7. **Assess whether the mother or caretaker will follow through to ensure that the medical problems will be addressed**
   - Has the mother been reliable in the past on medical follow-up?
   - Has anything new developed to prevent the mother from following up on recommended treatment (e.g. alcohol or drug problems, domestic violence, abusive, controlling boyfriend, or mental health problems)?
   - What resources does the family need to ensure compliance (e.g., transportation)?
   - Is the neglect representative of an isolated incident that occurred because of an unusual set of circumstances that has since been remedied? Or, are there risk factors which suggest that the child is at continued risk in their environment? Is the family in need of community resources that require the mobilization of social service agencies?
   - Evaluate whether Children's Protective Services should be involved. Most cases of neglect require an evaluation not only by medical personnel, but also by social services because there are many factors which contribute to a child being neglected. An extensive medical and psychosocial evaluation is key to assuring a good outcome.

B. LEGAL DEFINITIONS: SEVERE AND GENERAL NEGLECT

Neglect means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person. Severe and general neglect are defined below by Penal Code Section 11165.2.

1. **Severe neglect**
   Severe neglect means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutritionor medically diagnosed non-organic failure to thrive. Severe neglect also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Penal Code Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

2. **General neglect**
   General neglect means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

   For the purposes of this chapter, a child receiving treatment by spiritual means as provided in Section 16509.1 of the Welfare and Institutions Code, or not receiving specified medical treatment for religious reasons, shall not for that reason alone be

considered a neglected child. An informed and appropriate medical decision made by the parent or guardian after consultation with a physician or physicians who have examined the minor does not constitute neglect.

C. CLINICAL PRESENTATION OF NEGLECT

1. General Neglect

Children who are neglected may come to medical attention for a variety of reasons. Sometimes they are brought to the physician for an unrelated infectious illness, and evidence of neglect is apparent on physical examination. For instance, the child may appear dirty, smell of urine or stool, and be underweight. Other times, neglect may result in children sustaining a serious injury, such as being burned or drowned because of inadequate supervision. Children who receive inadequate food may present with growth impairment. Children with emotional neglect may experience behavioral or conduct problems in school. Some children die as a result of neglect, and these cases are usually evaluated by the medical examiner's office.

2.

Physical Neglect Refusal of Health Care	Failure to provide or allow needed care in accordance with recommendations of a competent health care professional for a physical injury, illness, medical condition, or impairment.
Delay in Health Care	Failure to seek timely and appropriate medical care for a serious health problem which any reasonable person would have recognized as needing professional medical attention.
Abandonment	Desertion of a child without arranging for reasonable care and supervision. This category includes cases in which children are not claimed within two days, and when children are left by parents/substitutes who give no (or false) information about their whereabouts.
Drug Endangered Children (DEC)	Children removed from drug manufacturing homes or homes with extensive drug use are often subject to severe neglect and accidental drug ingestion through common food and drink products in the home and exposure to trays of drug powder or crystals and residue.

Expulsion	Other blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others, or refusal to accept custody of a returned runaway.
Other Custody Issues	Custody-related forms of inattention to the child's needs other than those covered by abandonment or expulsion. For example, repeated shuttling of a child from one household to another due to unwillingness to maintain custody, or chronically and repeatedly leaving a child with others for days/weeks at a time.
Other Physical Neglect	Conspicuous inattention to avoidable hazards in the home; inadequate nutrition, clothing, or hygiene; and, other forms of reckless disregard for the child's safety and welfare, such as driving with the child while under the influence of drugs or alcohol, or leaving a young child unattended in a motor vehicle.

3. Inadequate Supervision — Child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without the parent/substitute knowing (or attempting to determine) the child's whereabouts.

4. Emotional Neglect

Inadequate Nurturance/ Affection	Marked inattention to the child's needs for affection, emotional support, attention, or competence.
Chronic/Extreme Abuse or Domestic Violence	Chronic or extreme spouse abuse or other domestic violence.
Permitted Drug/ Alcohol Abuse	Encouraging or permitting drug or alcohol use by the child, or cases where parent/guardian was informed of the problem and did not attempt to intervene.
Refusal of Psychological Care	Refusal to allow needed and available treatment for a child's emotional or behavioral impairment or problem in accord with competent professional recommendation.

Delay in Psychological Care	Failure to seek or provide needed treatment for a child's emotional or behavioral impairment or problem which any reasonable person would have recognized as needing professional psychological attention (e.g., severe depression, suicide attempt).
Other Emotional Neglect	Other inattention to the child's developmental/emotional needs not classifiable under any of the above forms of emotional neglect (e.g., markedly overprotective restrictions which foster immaturity or emotional overdependence, chronically applying expectations clearly inappropriate in relation to the child's age or level of development, etc.).

5. Educational Neglect

Permitted Chronic Truancy	Habitual truancy averaging at least five days a month is classifiable under this form of maltreatment, if the parent/guardian has been informed of the problem, and has not attempted to intervene.
Failure to Enroll/ Other Truancy	Failure to register or enroll a child of mandatory school age, causing the school-aged child to remain at home for nonlegitimate reasons (e.g., to work, to care for siblings) an average of at least three days a month.
Inattention to Special Education Needs	Refusal to allow or failure to obtain recommended remedial educational services, or neglect in obtaining or following through with treatment for a child's diagnosed learning disorder, or other special educational needs without reasonable cause.

6. Additional commentary on definitions

Medical neglect

Medical neglect may occur for acute problems, such as burns or injuries that are sustained accidentally; acute illnesses, such as gastroenteritis; or, for routine health maintenance. Some parents do access health care when their children have chronic problems, but then fail to follow the recommendations of the physician. For instance, a child with asthma may be prescribed several medications none of which are administered. As a result, the child may require repeated hospitalizations including admission to an intensive care unit.

Parents may utilize nontraditional medicine to treat their child's ailment. Examples of such practices include cao gio, or coining and moxibustion. Residual bruises from these practices may be mistaken for inflicted trauma. The use of non-traditional medicine is not condemned so long as it does not interfere with the child receiving appropriate medical care, and does not harm the child.

Child abandonment

Abandonment may involve frank abandonment, such as when a child is left in a trash dumpster, or, left alone, unprotected in a house or apartment without any adult supervision. Abandonment also occurs when a parent leaves the child in the care of others and then fails to return at an appointed time. Inadequate supervision is another form of abandonment as well as cases where both parents renege on their responsibilities as parents. Adolescents who are expelled from the home because of "misbehavior" are abandoned. These adolescents are frequently referred to as "throwaways."

Delay in accessing medical care

- Parents may not have the financial means to pay for healthcare, and they delay seeking treatment in the hope that the illness will resolve on its own;
- Parents are unsophisticated and do not appreciate the seriousness of the illness;
- Parents are overtly negligent, and simply do not provide for their child's health care needs;
- Parents are developmentally disabled or mentally ill and cannot properly care for their child; or,
- Parents whose child has been physically and/or sexually abused and they are trying to prevent this matter from coming to the attention of authorities.

Lack of supervision

Children who are left unsupervised may die as a result of such neglect. Common examples include children who die in house fires, from drowning, starvation, or inadequate medical care.

Religious beliefs

Some parents refuse medical care because of religious beliefs. Consult with Child Protective Services (CPS) and follow local protocol.

E. PATHOPHYSIOLOGY

There are many factors that contribute to neglect. Parental factors include maternal depression, parental substance abuse, maternal developmental delay or retardation, and lack of education. There are also features in the child that place additional stress on the parent-child relationship. Children with chronic disabilities may strain the resources of a family. Similarly, infants who have been born prematurely are at increased risk of being neglected or abused. Bonding between a mother and her premature infant may be interrupted because of the separation between the two during the early period after birth. Sometimes the “goodness of fit” between the infant and mother is lacking, and the pair do not act as a reciprocal dyad.

Certain family features are also associated with neglect. These include absent or negative interactions between family members. Poor parenting skills may also be noted. There is frequently social isolation and a single parent struggling with stressors such as unemployment, illness (including mental illness), prison, and eviction. On a more global scale, community and societal factors also contribute to the risk of neglect. The lack of child care in a community means that single parents may leave young children inadequately supervised in order to go to work. The lack of convenient public transportation may impact access to medical care. Poverty, violence, and substandard educational resources all contribute to neglect within certain populations. For instance, in neighborhoods perceived to be unsafe, children are frequently prohibited from playing outdoors and forming normal friendships because of safety concerns.

F. DIFFERENTIAL DIAGNOSIS

In any child who presents with a medical condition that may be related to neglect, healthcare providers must explore other explanations that could account for the findings. Children who appear to be malnourished may suffer from a number of medical problems that affect their ability to grow and gain weight. Children who present with injuries need to be evaluated for the circumstances surrounding the injury. Did the parent’s action contribute to the child being injured? Were these actions substandard, or would other parents have acted in a similar manner? For instance, if a child accidentally drowns in a bathtub, what reasons were given for leaving the child unattended?

The differential diagnosis of physical neglect depends on the presenting complaint. Children who are inadequately clothed may present with hypothermia. The differential diagnosis would include overwhelming sepsis, drug-exposure (COOLS - carbon monoxide, opiates, oral hypoglycemics [insulin], liquor, sedative-hypotics), or

environmental exposure. Children with refractory medical conditions such as intractable asthma or unstable diabetes may be viewed as medically fragile, if the issue of non-compliance is not raised. Failure to obtain medical care in a timely manner may result in disease progression to a point where diagnosis and medical intervention are more difficult.

This chapter is a condensed version of the article entitled "Child Neglect" by Carol Berkowitz, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER IX

IMPORTANT CONSIDERATIONS IN THE COLLECTION AND PRESERVATION OF EVIDENCE

A. CRIME LABORATORIES

Crime laboratories analyze and interpret evidence collected during the medical evidentiary examination. There are 31 public crime laboratories in California: 19 city and county laboratories and 12 California Department of Justice laboratories. There are also a number of privately operated crime laboratories. Crime laboratories have slightly different requirements for the collection and disposition of some types of evidence.

B. ENSURING EVIDENCE INTEGRITY

1. Key components of proper evidence handling are:

- Placing items in appropriate evidence containers;
- Labeling the evidence containers;
- Sealing the evidence containers;
- Storing evidence in a secure area; and
- Maintaining the chain of custody.

2. Use appropriate evidence containers to ensure that evidence cannot leak through the container, be lost, or deteriorate.

• Slide mailers	To protect slides.
• Bindles and other small containers	To protect items that can be easily lost such as crusted materials, soil, and small fibers. Bindles and other small protective containers are then placed into the evidence collection envelopes or boxes described below.
• Envelopes or boxes	To protect evidence such as swabs, reference hair samples, and foreign materials, and to hold the small containers listed above.
• Evidence kit container	A larger envelope or box to hold the individual evidence collection envelopes, small boxes, and slide mailers. The outside of the evidence kit container must have a chain of custody form printed on it or securely attached.
• Paper bags	To hold clothing.

The following chart, not meant to be all-inclusive, is a list of suggested containers for different types of evidence:

Items	Suggested Containers
• Swabs (dried)	• Envelopes • Boxes
• Slides (dried)	• Slide mailers
• Large foreign materials (e.g., hairs, grass)	• Envelopes
• Small or loose foreign materials (e.g., soil, paint, splinters, glass, fibers)	• Bindles placed into envelopes • Tapelifts in clear plastic containers
• Matted hair bearing crusted material	• Bindles placed into envelopes
• Fingernail scrapings or cuttings	• Paper bindles placed into envelopes • Sealable boxes
• Reference blood samples, liquid	• Lavender and/or yellow stoppered evacuated blood collection vials (according to local policy) placed in envelopes
• Saliva reference sample (dried)	• Envelopes
• Clothing	• Paper bags (not plastic)
• Toxicology samples Blood alcohol/toxicology Urine toxicology	• Gray stoppered evacuated blood collection vials • Tightly sealed clean plastic or glass container for urine samples

3. **Label evidence containers**
   Clearly label evidence to enable the person collecting it to later identify it in court and to ensure that the chain of custody is maintained. Many emergency departments use addressograph machines or computerized label generators to expedite labeling of evidence. Label envelopes or boxes with the following information:

   - Full name of patient;
   - Date of collection;
   - Description of the evidence including the location from which it was collected; and
   - Signature or initials of the person who collected the evidence and placed it in the container.

4. **Seal evidence containers**
   Properly seal evidence containers to ensure that contents cannot escape and that nothing can be added or altered by:

   - Securely taping the container (do not lick the adhesive seal); and
   - Initialing and dating the seal by writing over the tape onto the evidence container. Stapling is not considered a secure seal.
   - See **Appendix G**: Sealed Evidence Envelope for an example of proper sealing.

5. **Store evidence in a secure area**
   Evidence must be kept in a secure area when not directly in the possession of a person listed in the chain of custody.

6. **Maintain the chain of custody**
   The chain of custody documents the handling, transfer, and storage of evidence beginning with the collection of the evidence at the medical facility. It continues with each transfer of the evidence to law enforcement, the crime laboratory, and others. Complete documentation of the chain of custody information ensures there has been no loss or alteration of evidence prior to trial.

   - **Document all transfers of evidence with the following information:**
     - Name of person transferring custody;
     - Name of person receiving custody;
     - Date of transfer; and
     - Some jurisdictions also require documentation of time of evidence transfer. Consult your local crime laboratory for their requirements.

- **Chain of custody information can be:**
  - Printed by hand on an evidence envelope or box;
  - Securely attached to an evidence envelope or box; or
  - Preprinted on special envelopes, boxes and/or forms.
  - See **Appendix H** for a sample of the Chain of Custody Form.

C. COLLECTION OF CLOTHING

1. Collect clothing worn by the patient upon arrival at the hospital, if indicated.

2. Types of evidence on clothing

Clothing worn at the time of the assault may contain useful evidence:

- Rips, tears or other damage sustained as a result of the assault;
- Blood and other body fluids from the patient; and
- Foreign materials such as fibers, grass, soil, and other debris.

3. Collection procedures

- **Have patients remove their shoes first, then disrobe on two sheets of paper placed on top of one another on the floor.**
  The purpose of the bottom sheet is to protect the top sheet from dirt and debris on the floor. The purpose of the top sheet is to collect loose trace evidence which may fall from the clothing during disrobing. Using the disposable paper from examination tables is acceptable for this purpose.

- **Shoes**
  The shoes may be collected and packaged separately, if requested by the investigating agency or if indicated by the assault history.

- **Hairs, fibers, and debris**
  Collect loose hairs, fibers, and debris that fall from the clothing on the top sheet of paper placed on the floor for this purpose. After the clothing has been collected, fold the top sheet of paper (from the two sheets on the floor) into a large bindle to ensure that all foreign materials are contained inside. Label and seal to ensure that the contents cannot escape. Place into a large paper bag. The bottom sheet should be discarded.

- **Folding garments**
  Fold each garment as it is removed to prevent body fluid stains or foreign materials from being lost or transferred from one garment to another. Avoid folding the clothing across possible body fluid stains.

- **Wet clothing**
  It is preferable to dry clothing before packaging. If drying is not possible, wet clothing can be folded sandwiched between sheets of paper. After placing the item in a paper bag, clearly label the bag as containing a wet item and notify the law enforcement officer. Consult your local crime laboratory for additional recommendations.

- **Containers for clothing**
  Package each item of clothing in an individual paper bag. **Do not use plastic bags**. Plastic retains moisture which can result in mold and deterioration of biological evidence.

4. **Securely seal and label each clothing bag with the following information:**
   - Full name of patient;
   - Date of collection;
   - Brief description of item; and
   - Signature or initials of the person who collected the evidence and placed it in the container.

5. **Place small bags of clothing and the large paper bindle (from the floor) into large bag(s)**
   Place all bags (except those containing wet evidence) and the bindle made from the top sheet of paper into a large paper bag which has a chain of custody form printed on it or firmly attached. Multiple large bags may be used, if necessary.

D. PROCEDURES FOR BITE MARKS

1. **Photographing bite marks**
   Individuals can be identified by the size and shape of their bite marks. Properly taken photographs of bite marks and bruises can assist in the identification of the person who inflicted the injury. See Chapter X on Photography.

2. **Collecting saliva from bite marks after photo documentation**
   This sample can be examined by the crime laboratory for the presence of saliva and can be genetically typed and compared to potential suspects. Follow these procedures:

   - Swab the general area of trauma with a swab moistened with distilled, deionized or sterile water.

   - **Note:** If the patient history indicates a bite and there are no visible findings, swab the indicated area.

- Collect a control swab from an unbitten atraumatic area adjacent to the suspected saliva stain.

- Label, air dry, and package the evidence and control swabs separately.

3. Casting bite marks

- If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
- A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
- Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

E. BRUISING AND AGING OF INJURIES

Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.

- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in one to two days after the bruising develops more fully.

F. TOXICOLOGY

In addition to clinical implications, the presence of drugs in the patient's blood or urine may have legal significance.

1. Collect toxicology samples if the patient:

- Is unconscious;
- Exhibits abnormal vital signs;
- Reports ingestion of drugs or alcohol;
- Exhibits signs of memory loss, dizziness, confusion, drowsiness, impaired judgment;
- Shows signs of impaired motor skills;
- Describes loss of consciousness, memory impairment or memory loss;
- Reports nausea; and/or
- Exhibits other unexplained neurologic findings such as seizures.

2. Use these containers for toxicology samples:

Blood samples	Gray stoppered evacuated blood collection vials
Urine Samples	Tightly sealed clean plastic or glass container
Note: Refrigeration of toxicology samples is recommended.	

3. Collect toxicology samples as soon as possible

Alcohol metabolizes rapidly. Many drugs are also quickly eliminated from the body.

For alcohol analysis, collect a blood sample (5cc).
• Some drugs may also be detected in this sample if it is collected within 24 hours of ingestion. If this is a consideration, collect additional blood for drug analysis. • Be sure to cleanse the arm with a non-alcoholic solution.

If ingestion of drugs is suspected within 96 hours of the examination, collect the first available urine specimen.
• If the patient must urinate prior to the medical examination, the urine specimen for toxicology should be collected at that time. • “Clean catch” or “mid-stream” sampling methods are unsuitable for urine toxicology specimens. • Consult your local crime laboratory for recommended collection methods.

CHAPTER X

PHOTOGRAPHY

A. POLICIES AND CONSIDERATIONS

Photographs are recommended to supplement documentation of history and physical findings. They may be the only way to adequately document findings such as bite marks, bruises, or massive injuries.

- Photograph every potentially significant injury or finding.
- Photographs may be taken by trained medical forensic examination team members or be arranged with the local law enforcement agency.
- Patients may be concerned about privacy and modesty during photography. Sensitivity to these concerns should be exercised when deciding whether hospital personnel, a male or female law enforcement officer, or crime scene investigator takes the photographs.

B. PHOTOGRAPHIC PROCEDURES

Any good quality camera may be used as long as it can be focused for undistorted, close-up photographs and provides an accurate color rendition.

- Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
- Digital imaging is gaining acceptance in some jurisdictions as long as certain safeguards are in place. Consult with the local District Attorney's Office.
- Use adequate lighting whether the source is natural, flood, or flash.
- Take close-up photographs of bite marks and other wounds with the film plane as parallel to the subject area as possible. Minimize tilting of the camera to avoid distortion of the pictures.
- Include an accurate ruler or scale for size reference in the photograph. The scale should be in close proximity to and in the same plane as the injury or item being photographed. (A right-angle ruler, available commercially from police supply companies, is recommended. Consult your crime laboratory for vendors).
- Include a color bar in the photograph in the first image of the roll or series to ensure accurate color reproduction.

- Link the patient's identity and the examination date to the photographs of injuries and/or findings. This can be accomplished by:

  - Including a picture of the patient's identification card on the roll; or

  - Using a camera databack that can be programmed with the patient's medical record number or another non-duplicative numbering system.

- Avoid obscuring the injury with the ruler, identification label, or color bar. At least one or two photographs should be taken without the scale and/or color bar to orient the injury and to demonstrate that important evidence was not covered up.

- Additional photographs taken with a tangential light source (flash) may be used to enhance textured or irregular surface findings (e.g., bite marks, focal swelling, etc.).

C. GENERAL FORENSIC PHOTOGRAPHIC TECHNIQUES

At least three photographs of findings are required. These principles may be modified or adapted if multiple findings are in the same area.

- First, a "regional" or "orientation" photograph(s) showing the body part and the finding. (This shows the finding in the total context of the body region involved, as well as the anatomical orientation of the finding);

- Second, a close-up shot showing the whole finding; and

- Third, a second close-up using the scale to document size and camera position relative to the finding.

D. FORENSIC PHOTOGRAPHY COURSES

The California Clinical Forensic Medical Training Center (CCFMTC) offers courses on forensic photography. See **Appendix B** for information on how to access CCFMTC courses.

CHAPTER XI

CONSULTATION THROUGH TELEMEDICINE AND TECHNOLOGY

Telemedicine and telecourses are evolving rapidly through technology. Various types and resources are listed below:

A. POTS (PLAIN OLD TELEPHONE SYSTEM) AND POMS (PLAIN OLD MAIL SYSTEM)

Telemedicine began with POTS and POMS. Case consultation began through telephone consultation and using the mail system to send photographs of injuries to experts at other locations for assistance in interpretation and case management. This is the current most common method for obtaining consultation.

B. TWO TYPES OF VIDEO CONSULTATION: REAL TIME AND STORE AND FORWARD

1. Real time consultation

The term "real time" refers to live, clinician to clinician consultation most often between a tertiary hospital and an outlying clinic in a rural area. The rural clinician may need back up in a particular specialty, for example, obstetrics or dermatology. A clinic is scheduled for certain times and days of the week and the tertiary hospital physician is scheduled to consult with the rural clinician at that time. Video cameras are permanently set up and the tertiary center clinician monitors the examination and observes the findings at the same time as the rural clinician.

2. Store and forward consultation

The term "store and forward" means to photograph or videotape the examination, to save or "store" the videotape or photograph, and to forward it to a specialist or expert at a tertiary center for consultation. Software exists to transmit photographic and videotaped images over telephone lines. Hardware requirements include a computer, monitor, and VCR at both sites. Confidentiality and the transmission of medical records have been addressed in the development of this software.

Store and Forward has been found to be most practical in the field of forensic medicine to evaluate child physical and sexual abuse cases. First, the timing of forensic exams is unpredictable and given the low volume in rural areas the "scheduled clinic" approach is more difficult to implement. Second, the time demands are high upon the few forensic medical experts in child abuse and sexual assault. A Store and Forward system makes it easier to view transmitted photographs and videotapes on a time schedule that works for the forensic expert. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

3. **Interactive video consultation**
   Video consultation is generally focused on one or more case studies and is handled through point-to-point computer transmissions. This type of consultation is held around a computer monitor and four to six professionals (or more depending on the size of the monitor or screen) can be accommodated at each site. Point-to-point refers to a connection between a tertiary hospital and one or more outlying areas. A simultaneous telephone connection on a speaker phone is set up and visual images are transmitted on the computer monitor.

4. **Telecourses or distance learning through satellite transmissions**
   These terms are used to refer to courses transmitted simultaneously to different sites to a live audience. A tertiary center broadcasts the course to predetermined sites.

C. CD ROM COURSES

Reference materials and courses are now being developed on CD ROM. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

CHAPTER XII

HOSPITAL SCAN TEAM MODELS

SCAN (Suspected Child Abuse and Neglect) Teams are multi-disciplinary teams involved in the identification and treatment of child victimization. The mission of these teams is to enhance the identification, reporting, and case management of child abuse and neglect cases through a multi-disciplinary approach.

A. HISTORY OF SCAN TEAMS

The first hospital-based child protection teams were established in the late 1950's at Pittsburgh Children's Hospital, the University of Colorado Medical Center, and Children's Hospital in Los Angeles.

Tasks of SCAN Teams include, but are not limited to:

- Performing case review of all child abuse and neglect reports;
- Reviewing medical reports for evaluation, follow-up and referrals;
- Coordination of treatment planning;
- Maintaining a central log of cases and/or a data system;
- Preparing an annual summary report;
- Providing training and education to the various disciplines and professionals involved in cases;
- Providing expert testimony in court; and,
- Providing a focus for research.

B. PRIMARY CARE FACILITY TEAMS

1. Team membership

A physician and medical social worker and/or nurse are designated as resource specialists in the area of child maltreatment.

2. Roles and responsibilities

- Case consultation to other health care providers in their setting regarding the assessment of child maltreatment and the development of an adequate information base for diagnosis;
- Guidance on making the required telephone and written reports;
- Consultation on developing a treatment plan for follow-up with the family;
- Serve as liaison with area hospitals, law enforcement agencies, child protective services, and other public agencies in all cases of child abuse and neglect seen at the facility;
- Provision of training and education for the staff at the facility;
- Developing reporting protocols and procedures; and,
- Case follow-up.

C. SECONDARY LEVEL FACILITY TEAMS

1. Team membership

These teams have a core group of professionals such as physicians, mid-level practitioners, nurses, social workers, child development and mental health specialists, and psychiatrists. Team members have specialized training and expertise in the recognition of child maltreatment, assessment and evaluation, the mechanics of reporting and public agency response, and community resources for treatment and follow-up. Other specialists may be called upon as needed for consultation, such as radiologists, ophthalmologists, and dentists. At this level, a representative from the local child protective services and/or law enforcement agency is usually a member.

2. Roles and responsibilities

- Availability of 24-hour consultation to hospital staff in order to provide immediate assistance on cases. The consultation service approach does not require the SCAN Team to take over the case from the treatment team, but rather, consultation is provided by telephone or in person. Referrals typically come from the Emergency Department, newborn nurseries, inpatient pediatric ward, burn unit, and primary care clinics, such as pediatrics, family medicine, and prenatal care.
- Consultation may also be provided to the psychiatric unit and dental clinics. In many hospitals, consultation with a member of the SCAN Team is required. Any faculty or staff, regardless of discipline, is required to seek consultation with the Team whenever there is concern about maltreatment.
- Guidance for interviewing the child and parents.
- Case management with law enforcement and Child Protective Services (CPS).
- Consultation on clinical studies needed to assist in making the diagnosis.
- Forensic medical evidence collection, related consent issues, dealing with the family, and making the reports.
- Case reviews at regularly scheduled multi-disciplinary meetings.
- Provision of expert testimony in Juvenile and Superior Court.

Some teams meet weekly and review every case referred, regardless of whether a report was made. Other teams review only complex cases in which the diagnosis is more difficult. These case reviews are usually more effective when the treating physician, nurse, social worker, and other relevant staff attend and present their cases, rather than having a “paper review” of the case. Cases where reporting was recommended and completed are reviewed for follow-up. Cases that do not result in reporting are also reviewed to determine other case management alternatives. Multi-disciplinary case reviews are particularly helpful in very complex

and difficult to sort out cases such as those involving medically fragile/chronically ill children with issues of medical noncompliance, failure-to-thrive, abusive head trauma, sexual abuse, medically fragile/chronically ill children where there is noncompliance, and Munchausen by Proxy.

The need to consider complex medical, developmental, social, and psychological data may require a separate meeting on a given case. Recommendations made by the SCAN Team are documented.

3. **Case follow-up**
   Follow-up reporting on case disposition is important to inform the SCAN Team about the response of the child protection system to the case, to know whether the Team's recommendations were acted upon by the public agencies and whether the recommended intervention, services, and treatment plan were put into place. Follow-up also involves the SCAN Team to ensure that all procedures are followed and reports are completed. Without follow-up, the Team is ineffective and risks being perceived as unrealistic and impractical by child protection and other community agencies.

4. **Centralized log of all referred cases**
   A patient identification code, the child's age, gender, referral source, and type of suspected maltreatment are basic elements of the database. The database allows for identification of major trends such as an increase/decrease in the number of reports of specific types of abuse and an increase in the overall referrals from the Emergency Department, law enforcement, and CPS. Depending upon the scope of data collected and recorded, other trends may be identified and lead to further clinical investigation (e.g., an increase in the number of babies delivered exposed to methamphetamines or cocaine, more cases from a particular part of the institution's geographic service area, etc). Documenting trends can assist in garnering support for additional community resources or changes in service-delivery.

   An annual summary report is useful to document the volume of cases referred, trends, and other activities required of, or undertaken by the SCAN Team. Teaching, research, and quality assurance activities are included in this report. Progress on grants obtained and updates on hospital programs addressing child abuse prevention and treatment issues are also included.

5. **Training and education for mandated reporters**
   A master calendar of annual training programs for medical and hospital staff to provide regular updates on child abuse topics is particularly helpful in teaching hospital institutions where there is continual influx of new faculty and staff or for use

in Grand Rounds educational presentations. SCAN Teams provide valuable training to child protection social workers, law enforcement, and criminal and dependency court personnel on medical evidentiary exam findings, and updates from the scientific literature. These training programs are opportunities for communication to increase understanding and appreciation of each discipline's role and methodology for assessment/investigation.

6. Consultation to community agencies

Child Protective Services (CPS), law enforcement, prosecutors, and the courts seek consultation and expert opinion. CPS may seek consultation from the Team on a case of a child who has never been seen at the hospital. SCAN Teams afford access to physicians and other health care providers with expertise in diagnosing child abuse and neglect.

7. Prevention activities

Child abuse prevention activities include: sponsoring awareness-raising campaigns in the hospital and community during Child Abuse Prevention Month; sponsoring annual conferences; developing and distributing materials at patient visits and in public areas of the hospital and community on various topics; providing parenting classes and support groups; providing educational materials to parents of newborns; and conducting child safety campaigns.

Many hospital administrations recognize the role SCAN Teams play in reducing and managing risk. Another value-added element is economy of labor – expert consultation results in improved documentation of cases, which in turn, reduces the volume and time spent on communications with investigating agencies and court appearances. If the situation does not warrant a mandated report, the team may contribute other strategies to use to address the family's problems, or suggest treatment resources.

D. TERTIARY FACILITY TEAMS

1. Coordinated approach to patient care

Some communities are developing highly trained specialized examiner programs using physicians, mid-level practitioners (nurse practitioners and physician assistants), and nurses within their scope of practice. Each model has a physician medical director. Referrals are received from throughout the region or county. There are various acronyms for these teams: SCAN (Suspected Child Abuse and Neglect), CARE (Child Abuse Response Examiners) and CAST (Child Abuse Services Team).

2. Key features of tertiary teams

- Medical leadership in the community, region, and statewide;
- Regional resource center;
- Coordinated team approach;
- Prompt forensic medical examinations for acute cases and consultation;
- Highly trained medical personnel;
- Defined areas of expertise in either child physical or sexual abuse, or both;
- Pre-authorization for reimbursement based upon negotiated contracts;
- Dedicated exam space and equipment;
- Immediate patient support and advocacy;
- Coordinated medical and law enforcement interviews;
- Specialized training for all team members;
- Peer review;
- Continuous quality improvement;
- Collaboration and cooperation with community resources;
- Utilization of best practice standards;
- Inclusion of public agencies in team membership (e.g., law enforcement, child protective services, Multi-Disciplinary Interview Center, and public health nurses);
- Provision of expert testimony throughout the region, state, and nationally;
- Participation in public policy committees and initiatives at the state and national levels;
- Telemedicine consultation and resource center;
- Mental health diagnostic and treatment services;
- Coordination for regional CQI, photo and case review meetings for other examiners to expand expertise;
- Research and publication in peer reviewed journals; and,
- Major conferences, symposia, and training programs.

3. Continuing quality improvement (CQI) and photo review

Formal CQI review is an essential standard of practice for medical evidentiary examination teams. Some community hospitals have developed CQI for the medical team operations and participate in regular CQI with the local law enforcement agencies and Children's Protective Services. CQI sometimes includes brief evaluation forms from the crime laboratory regarding the quality of evidence collection, preservation, and handling for the examination team on a per case basis. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

E. HOSPITAL SCAN TEAMS: HISTORY OF SPAWNING NEW PROGRAMS

1. Development of Child Protection Centers

The early SCAN Teams opened up lines of communication between medical facilities and investigative agencies; increased awareness about child abuse and neglect; provided community education; developed cooperative agency partnerships; provided professional training for law enforcement officers, prosecutors, and investigative social workers on how to interpret medical evidentiary exam findings; and, in many instances, established foundational leadership in the community to address the problem of child abuse and neglect.

Beginning in the 1980's, Child Protection Centers emerged out of SCAN Teams, and built upon the foundation established by the SCAN Team model. The hospital-based centers began to operate on a much larger multi-disciplinary scale. These programs first developed in response to the need for specialized child sexual abuse medical evidentiary examinations and the higher level of collaboration required with investigative agencies. From this foundation, other services began to be developed and offered such as foster care health programs providing clearance and comprehensive medical exams with screening for medical, developmental, dental, and mental health problems; comprehensive mental health programs including individual, group, and family therapy; research; and more formalized regional and statewide conferences and training programs.

These programs are often extensively involved in addressing larger child protection system policy issues; initiating system change to improve intervention services; developing interagency protocols for case management; and engaging in legislative and public policy advocacy at the State and Federal level.

2. Multi-Disciplinary Interview Centers (MDICs) or Multi-Disciplinary Interview Teams (MDIT)

MDICs and MDITs arose from local multi-disciplinary teams and coordinating councils and, in many instances, the original SCAN Team. These programs ensure coordinated case investigations and involve commitments from agencies to participate in a multi-disciplinary, multi-agency approach to interview children utilizing child interview specialists.

These programs are often called Multi-Disciplinary Interview Centers (MDICs) or Multi-Disciplinary Interview Teams (MDITs). In some cases, the MDIC/MDIT is located at the hospital. In most instances, the MDIC/MDIT is located at a public agency such as the District Attorney's Office or Child Protective Services, and makes referrals to the hospital's child abuse specialists for forensic medical exams.

Information from this chapter is based on the article entitled “Hospital SCAN (Suspected Child Abuse and Neglect) Team Models” by Nancy C. Hayes, L.C.S.W. from the book Child Abuse and Neglect: Guidelines for identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment, and case management of carious forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor’s Office of Criminal Justice Planning (now the Governor’s Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER XIII

CHILD DEATH REVIEW TEAMS

A. PURPOSES OF CHILD DEATH REVIEW TEAMS

Child Death Review Teams (CDRTs) are multi-agency, multi-disciplinary state and/or local teams that systematically review child deaths within a specific geographic area. They play a critical role in helping to identify child abuse and neglect fatalities and other preventable child deaths. Local CDRTs are often involved in the case management of child death investigations. State teams primarily serve the local teams or gather data for systems management and policy interventions. Many benefits have accrued from the work of CDRTs, including more accurate identification of child deaths due to child maltreatment, more effective determination of the underlying cause of suspicious deaths, identification of gaps and breakdowns in agencies and systems designed to protect children, and implementation of various prevention interventions.

1. Penal Code Section 11166.7 establishes County Child Death Review Teams

Each county may establish an interagency child death team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Interagency child death teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.

Each county may develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death, or whether child abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.

In developing an interagency child death team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including but not limited to, the following:

- Experts in the field of forensic pathology;
- Pediatricians with expertise in child abuse;
- Coroners and medical examiners;

- Criminologists;
- District Attorneys;
- Child Protective Services staff;
- Law enforcement personnel;
- Representatives of local agencies involved with child abuse or neglect reporting;
- County health department staff who deal with children's health issues; and
- Local associations of professionals listed above.

2. Roles and responsibilities of Child Death Review Teams

Child Death Review Teams may perform any or all of the following tasks:

- Review and assess whether child deaths are homicides associated with abuse or neglect;
- Review and assess the causes of all child deaths with the intent of identifying circumstances surrounding preventable deaths;
- Improve the criminal investigation and prosecution of child abuse homicides;
- Improve dependency investigations and the protection of surviving siblings;
- Serve as a quality assurance team for death investigations;
- Design and implement cooperative protocols for investigation of child deaths;
- Improve linkages, communication and coordination among law enforcement, social services, local health agencies, the District Attorney's Office, the coroner and others;
- Provide a forum for agencies to resolve conflicts;
- Collect uniform and accurate statistics on child deaths; and,
- Identify public health issues and make recommendations to county and state policymakers and legislators.

3. Team Membership

Core members:

- County Medical Examiner or Coroner;
- Law Enforcement Agencies;
- Child Protective Services;
- District Attorney's Office; and
- Pediatrician (preferably with experience in child abuse evaluations).

Additional members:

- Child advocate;
- School representative;
- Fire Department or Emergency Medical Services;
- Mental Health representative;

- Liaison with the California Highway Patrol (CHP) (if available);
- Epidemiologist or data analyst (e.g., Office of Vital Statistics;
- Probation Officer; and
- Injury Control Specialist.

4. Selection criteria

CDRTs systematically select child deaths for review using predetermined criteria. Usually cases are drawn either from the deaths reported to the coroner or from vital statistics death certificates. Many counties (e.g., small and mid-sized counties) review all child deaths, whereas larger counties may have more selective review criteria (e.g., only coroner cases). Age criteria usually range from selecting only children under 7 to selecting all children under 20. The most common age criterion is children under 18 years of age.

Examples of review criteria used by various teams:

- All children under age 18;
- Coroner's cases of all children's deaths;
- "Unexpected", "unexplained", or "suspicious" deaths;
- Deaths under a certain age;
- Deaths of children known to Child Protective Services; and
- Deaths from certain causes.

Recommended minimum criteria:

- All coroner child death cases; and
- All children under 18 years of age.

5. Recommended "best practice" procedures

- Systematic intake and review of cases drawn by protocol from the coroner and/or vital statistics records;
- Teams function as a peer review, respecting confidentiality and sharing information across agency lines;
- Authentic peer review with no agency controlling or censuring the information, discussion, or activity of another;
- Multi-disciplinary team membership of investigative agencies with administrative support to collect, analyze, publish, and distribute the data locally for the Board of Supervisors, directors of public agencies, and in newspaper(s) for the public; and
- Capability for promoting and implementing basic or advanced procedures, policies, and prevention programs through team member agencies (e.g. , County Health Department or Child Abuse Prevention Council) or other community resources.

B. ROLE OF THE STATE CHILD DEATH REVIEW COUNCIL

The California State Child Death Review Council (CSCDRC), established under the auspices of the Department of Justice (DOJ), was organized to establish leadership at the state level with representatives from key state agencies and associations. This statewide council was established pursuant to Penal Code Section 11166.9. According to the legislative mandate, it shall be the duty of the CSCDRC to oversee the statewide coordination and integration of state and local efforts to address fatal child abuse and neglect, and to create a body of information to prevent child death. Goals of the State Council include:

- Create and maintain an integrated, automated statewide data system for all counties and relevant state agencies;
- Promote the use of standardized forms and data collection protocols;
- Foster communication between state and local teams, other states, federal agencies and national associations, including dissemination of data and a statewide directory;
- Address local, state, and federal policy legislation issues and guidelines;
- Seek additional resources and funding for county team efforts;
- Support the development of domestic violence death review teams;
- Promote increased awareness of the relationship between domestic violence and child abuse;
- Promote development of a model for small counties (e.g., multi-county teams or cluster groups for counties with populations under 20,000);
- Raise visibility of child deaths and child death review teams through public education programs and the annual state report;
- Promote education and training for child death review team members;
- Develop an evaluation process to assess team effectiveness;
- Encourage continued research efforts at the state and federal level regarding child deaths and related issues; and
- Provide training and technical assistance to local teams.

This chapter is a condensed version of the articles entitled “Child Death Review Teams” by Michael Durfee, M.D. and Stephen J. Wirtz, Ph.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor’s Office of Criminal Justice Planning (now the Governor’s Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER XIV

MENTAL HEALTH AND DEVELOPMENT ISSUES AND REFERRALS

A. PSYCHOLOGICAL AND BEHAVIORAL OUTCOMES ASSOCIATED WITH CHILD PHYSICAL ABUSE

1. Psychological and Social Problems Associated with Physically Abused Children

- Post-traumatic Stress Disorder (PTSD);
- Generalized anxiety;
- Depression;
- Withdrawal;
- Feeling different from others and socially isolated;
- Poor interpersonal social skills; and
- Poor school performance and/or underachieving

2. Behavioral problems associated with physically abused children

- Difficult or aggressive behavior;
- Oppositional and/or defiant behavior;
- School problems; and
- Bullying and fighting behavior

3. Recommended mental health treatment modalities

- Individual therapy;
- Group therapy;
- Parent-Child Interaction Therapy (PCIT); and
- Home visiting programs

B. PSYCHOLOGICAL AND BEHAVIORAL OUTCOMES ASSOCIATED WITH CHILD NEGLECT

1. Psychological, developmental, and behavioral outcomes associated with child neglect

- Poor impulse control and creativity;
- Poor academic performance;
- Poor interpersonal social skills;
- Poor language comprehension;
- Speech delays;
- Lower IQ scores;
- Not “ready to learn” in school;
- Withdrawn and reticent to participate in activities;
- Depression;

- Anxiety; and
- Vulnerability for developing alcohol and drug abuse problems and for developing significant mental health problems

2. Recommended treatment modalities

- Home visiting programs;
- Individual therapy; and
- Group therapy

C. MENTAL HEALTH TREATMENT

1. Indicators for mental health treatment for abused and neglected children

- History of neglect, physical and sexual abuse;
- Death of a sibling or a parent;
- Child or parent history of alcohol and/or drug abuse;
- Depression, sadness, withdrawal and avoidance of others, fearful;
- Angry, agitated;
- Signs of stress (e.g., unable to go to sleep, wakes during the night, eating problems, quick temper, easily frustrated);
- Acting out behavior (e.g., aggressive with peers, caregivers, teachers);
- History of torture;
- Mistreatment of animals;
- Firesetting;
- School problems (e.g., poor grades, poor concentration, little participation in activities);
- Change or deterioration of behavior;
- Suicidal ideation;
- Risk of placement disruption due to behavioral difficulties;
- Difficulties with self-care not due to developmental disability;
- Hallucinations or delusions; and
- History of receiving psychotropic medication.

2. **Purpose and types of mental health treatment**
   The purpose of mental health treatment is to alleviate psychological and behavior symptoms and to facilitate the development and maintenance of healthy functioning across an individual's life domains (e.g. home, work, or school). The primary treatment modalities are:

   - Individual therapy (e.g., various psychodynamic therapeutic models, sand tray, cognitive-behavioral therapy, and play therapy);
   - Dyadic therapy (e.g., Parent-Child Interaction Therapy);
   - Group therapy; and
   - Family therapy.

   Home-based and family-centered service approaches may also be helpful in supporting children and families. Home visiting programs, family resource centers, family conferencing, and wraparound social service support models are being developed in many communities to enhance existing systems of care.

3. **Indicators for a psychological evaluation**
   Sometimes the clinical or psychosocial assessment indicates a need for a psychological evaluation to obtain more detailed information regarding the child's psychological functioning or when the diagnosis is unclear. For a treatment plan to be successful, it is important to know, for example, whether the child is suffering from Post Traumatic Stress Disorder (PTSD) or has Attention Deficit Hyperactivity Disorder (ADHD) because the symptoms can be similar but the treatment plans are different.

   Psychologists are the only mental health professionals accredited to perform psychological testing and evaluation, and they employ a battery of tests that evaluate:

   - **Cognitive functioning**
     Processing information, learning strengths and weaknesses, memory, verbal and nonverbal abilities, and academic abilities.

   - **Affective functioning**
     Emotions, fantasies, and feelings.

   - **Adaptive functioning**
     How an individual functions in the world in areas such as communication, daily living skills and socialization.

- **Pathological functioning**
  Ways in which the individual's internal conflicts and drives distort or overwhelm the ability to deal effectively with the demands of external reality.

- **Personality**
  Clinical symptoms, personality traits and patterns, and interpersonal functioning.

- **Developmental functioning**
  Cognitive, communication, social, adaptive, and/or motor development.

4. Psychological testing

Psychological testing can address these questions about an individual:

- What are the client's intellectual strengths and limitations?
- Is there evidence of neurological immaturity or impairment?
- What is the nature of past knowledge and achievements, interests, and aptitudes?
- How adequate is reality testing?
- What is the quality of interpersonal relationships?
- What are the adaptive strengths (application of assets and liabilities to new problems, flexibility of approach, persistence, frustration tolerance, and reaction to novelty)?
- To what degree are impulses maintained under control (under-controlled or over-controlled)?
- How does the person defend psychologically (protect the self from feelings, ideas, and experiences that create anxiety through avoidance, repression, fighting or aggression, etc.) against unacceptable internal needs and demands or external experiences? How rigid are the client's defenses?
- What are the areas of conflict?
- Does the child have a psychiatric disorder?
- What is the child's developmental functioning?
- What treatment strategies and services would be most effective in improving functioning?
- What support services would be helpful to the parents or caregivers?

5. Indicators for a psychiatric evaluation

Psychiatric evaluations are sometimes needed to evaluate complex issues that may need to be resolved with hospitalization or medication support for relief of symptoms. Psychiatric evaluations are helpful with parents and children in cases involving:

- Previous psychiatric history;
- Psychotic symptoms such as hallucinations (e.g. , hearing voices), delusional thinking (odd or magical beliefs) or bizarre ideation;
- Suicidal ideation or attempts or self-destructive behaviors;
- Significant anxiety (fears/worrying) and depression (sadness/withdrawal/anger/passivity);
- Episodes of dissociation, (i.e. “spacing out”);
- Inattention, forgetfulness, distractibility, or difficulty concentrating;
- Aggressive outbursts (whether toward others or animals) or firesetting;
- Hyperactivity or excessive energy;
- Changes in sleeping or eating patterns;
- Pain or any medical symptom that does not have medical basis;
- Regressed behaviors (e.g., bedwetting in a previously “dry” child);
- Inappropriate sexualized behaviors; and/or,
- Obsessive thoughts or compulsive behaviors.

D. CHILD DEVELOPMENT EVALUATIONS

1. Indicators for making a referral for a developmental evaluation

Early diagnosis gives the child with developmental disorders an important head start in school or identifies reasons behind school problems. It is especially critical that a treatment plan be determined and implemented before or during the child’s early school years. Guidelines for referral for a developmental evaluation include:

- Delays in reaching early developmental milestones (such as sitting, crawling, babbling or using words, and learning new social or play skills);
- Language delay, cognitive delay, fine and gross motor skill delay;
- Hyperactivity or behavior problems;
- Regression (loss) of skills;

- School or learning problems;
- Atypical behaviors (e.g., inability to interact or play with other children, inattention, daily living skill and self-care deficits);
- History of prenatal drug exposure, low birth weight or prematurity;
- Inability to understand or follow directions, or inability to explain ideas or speak clearly; and/or
- Children with histories of child abuse and neglect.

2. Formal Developmental Evaluation

A formal child developmental evaluation requires a multi-disciplinary team which includes a clinical psychologist with specialized training in child development and developmental disorders, a Developmental-Behavioral Pediatrician, and a social worker with training in child development. Assessment requires knowledge of typical and atypical development, cultural and social aspects of behavior, psychometric concepts, multiple diagnostic measures and techniques, ethnical/legal issues and an understanding of the child welfare and other intervention service systems.

This chapter is a condensed version of the article entitled "Developmental Issues in Abused and Neglected Children" by Theresa Witt, Ph.D. and Robin Lee Hansan, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

APPENDICES

APPENDIX A
California Penal Code Section 11171

This legislation was introduced by Senator Figueroa and signed into state statute August 2002.

11171. (a) (1) The Legislature hereby finds and declares that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations.

(2) Enhancing examination procedures, documentation, and evidence collection relating to child abuse or neglect will improve the investigation and prosecution of child abuse or neglect as well as other child protection efforts.

(b) The agency or agencies designated by the Director of Finance pursuant to Section 13820 shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California State District Attorneys Association, the California State Sheriffs
Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Clinical Forensic Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocol for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 19823.5.

(c) The form shall include, but not be limited to, a place for notation concerning each of the following:

(1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.

(2) Addressing relevant consent issues, if indicated.

(3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.

(4) The performance of a physical examination for evidence of child physical abuse or neglect.

(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.

(c) The forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of the agency or agencies designated by the Director of Finance pursuant to Section 13820 and subject to the confidentiality laws pertaining to the release of a medical forensic examination records.

(D) The forms shall be made accessible for use on the Internet.

APPENDIX B

CALIFORNIA MEDICAL TRAINING CENTER AT UC DAVIS

CALIFORNIA
MEDICAL
TRAINING
CENTER

Improving the Healthcare Response to Violence

California Clinical Forensic Medical Training Center (CCFMTC)
University of California, Davis
3300 Stockton Boulevard
Sacramento, CA 95820

Telephone: (916) 734-4141
Toll free: (888) 705-4141
Fax: (916) 734-4150
E-mail: mtc@ucdmc.ucdavis.edu
Website: www.ccfmtc.org

The CCFMTC offers skill-based training for performing quality medical/evidentiary examinations for victims of child physical abuse, child sexual abuse, sexual assault, domestic violence, and elder and dependent adult abuse and neglect. Training modalities include multi-day, skill-based training and one-to-eight hour lectures. Telecourses, case consultation, Internet, and CD-ROM self-instruction courses are under development.

The California Penal Code includes eight specific objectives for the CCFMTC:

- Develop and implement a standardized training program for medical personnel that has been reviewed and approved by a multi-disciplinary peer review committee.
- Develop a telecommunications system network between the Training Center and other areas of the state, including rural and midsize counties. This service shall provide case consultations to medical personnel, law enforcement, and the courts and provide continuing medical education.
- Provide basic, advanced, and specialized training programs.

- Develop guidelines for the reporting and management of child physical abuse and neglect, domestic violence, and elder abuse and neglect.
- Develop guidelines for evaluating the results of training for the medical personnel performing examinations.
- Provide standardized training for law enforcement officers, district attorneys, public defenders, investigative social workers, and judges on medical evidentiary examination procedures and the interpretation of findings.
- Promote an interdisciplinary approach in the assessment and management of child abuse and neglect, sexual assault, elder abuse, domestic violence, and abuse or assault against persons with disabilities.
- Provide training in the dynamics of victimization, including, but not limited to, rape trauma syndrome, battered woman syndrome, the effects of child abuse and neglect, and the various aspects of elder abuse.

APPENDIX C

MANDATORY REPORTERS DEFINED BY PENAL CODE SECTION 11165.7

As used in this article, “mandated reporter” is defined as any of the following:

- A teacher.
- An instructional aide.
- A teacher’s aide or teacher’s assistant employed by an public or private school.
- A classified employee of any public school.
- An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school.
- An administrator of a public or private day camp.
- An administrator or employee of a public or private youth center, youth recreation program, or youth organization.
- An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.
- Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.
- A licensee, an administrator, or an employee of a licensed community care or child day care facility.
- A headstart teacher.
- A licensing worker or licensing evaluator employed by a licensing agency as defined in Section 11165.11.
- A public assistance worker.
- An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.
- A social worker, probation officer, or parole officer.
- An employee of a school district police or security department.
- Any person who is an administrator or presenter of, or counselor in, a child abuse prevention program in any public or private school.
- A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.
- A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.
- A fire fighter, except for volunteer fire fighters.
- A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.
- A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.
- A marriage, family, and child therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.
- An unlicensed marriage, family, and child therapist intern registered under Section 4980.44 of the Business and Professions Code.
- A state or county public health employee who treats a minor for venereal disease or any other condition.
- A coroner.
- A medical examiner, or any other person who performs autopsies.
- A commercial film and photographic print processor, as specified in subdivision (e) of Section 11166. As used in this article, "commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.
- A child visitation monitor. As used in this article, "child visitation monitor" means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.
- An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:
  - "Animal control officer" means any person employed by a city, county, or city and county for the purposes of enforcing animal control laws or regulations.
  - "Humane society officer" means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.
- A clergy member, as specified in subdivision (c) of Section 11166. As used in this article, "clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.
- Any custodian of records of a clergy member, as specified in this section and subdivision (c) of Section 11166.
- Any employee of any police department, county sheriff's department, county probation department, or county welfare department.
- An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the Rules of Court.

- Volunteers of public or private organizations whose duties require direct contact and supervision of children are encouraged to obtain training in the identification and reporting of child abuse.
- Training in the duties imposed by this article shall include training in child abuse identification and training in child abuse reporting. As part of that training, school districts shall provide to all employees being trained a written copy of the reporting requirements and a written disclosure of the employees' confidentiality rights.
- School districts that do not train their employees specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws shall report to the State Department of Education the reasons why this training is not provided.
- The absence of training shall not excuse a mandated reporter from the duties imposed by this article.

APPENDIX D

SUSPECTED CHILD ABUSE REPORT FORM
Department of Justice (DOJ) SS 8572

Department of Justice (DOJ) Form SS 8572 can be downloaded from this website:

http://caag.state.ca.us/childabuse/forms.htm

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip				TELEPHONE ( )
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS		GRADE
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME			TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO			DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )			BUSINESS PHONE ( )
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )			BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip				TELEPHONE ( )
OTHER RELEVANT INFORMATION				

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

APPENDIX E

CALIFORNIA CHILD PROTECTIVE SERVICES AGENCIES

For current contact information, go to the Department of Social Services website at <*http://www.dss.cahwnet.gov/cfsweb/Res/pds/EmergencyR_315.pdf*>.

ALAMEDA COUNTY
Alameda County Welfare Dept.
8000 Edgewater Drive
Oakland, CA 94621

Main: (510) 259-1800

ALPINE COUNTY
Alpine County Dept. of Social Services
P.O. Box 277
Markleeville, CA 96120

Main: (530) 694-2235
Hotline: (888) 755-809

AMADOR COUNTY
Amador County Dept. of Social Services
1003 Broadway
Jackson, CA 95642

Days: (209)223-6550
Evenings: (209) 223-1075

BUTTE COUNTY
Butte County Dept. of Social Services
#1 County Center Drive
Oroville, CA 95249

Oroville: (530) 538-7617
Others: (800) 400-0902

CALAVERAS COUNTY
Calaveras County Dept. of Social Welfare
Government Center
San Andreas, CA 95249

Days: (209) 754-6452
After Hours: (209) 754-6500

COLUSA COUNTY
Colusa County Dept. of Social Welfare
P.O. Box 370
Colusa, CA 95932

Main: (530) 458-0280

CONTRA COSTA COUNTY
Contra Costa County Employment & Human Services.
2530 Arnold Drive, Suite 300
Martinez, CA 94553-4359

Central: (925) 646-1680
West: (510) 374-3324
East: (925) 427-8811

DEL NORTE COUNTY — Main: (707) 464-3191
Del Norte County Welfare Dept.
880 Northcrest Drive
Crescent City, CA 95531

EL DORADO COUNTY
El Dorado County Dept. of Social Services — S. Tahoe: (530) 544-7236
3057 Briw Road #A — Placerville: (530) 642-7100
Placerville, CA 95667

FRESNO COUNTY
Fresno County Dept. of Adult Protective Services — Main: (559) 255-8320
P.O. Box 1912
Fresno, CA 93750-0001

GLENN COUNTY
Glenn County Dept. of Social Services — Main: (530) 934-6520
420 East Laurel Street
Willows, CA 95988

HUMBOLDT COUNTY
Humboldt County Dept. of Social Services — Main: (707) 445-6180
929 Koster Street
Eureka, CA 95501

IMPERIAL COUNTY
Imperial County CWS Agency — Main: (760) 337-7750
2995 South 4th Street, Suite 105
El Centro, CA 92243

INYO COUNTY
Inyo County Welfare Dept. — Main: (760) 872-1727
Drawer A, Extension 2338
Independence, CA 93526

KERN COUNTY
Kern County Dept. of Human Services — Main: (661) 631-6011
P.O. Box 511
Bakersfield, CA 93302

KINGS COUNTY

Kings County Human Services Agency
1200 South Drive
Hanford, CA 93230

Main: (559) 582-8776

LAKE COUNTY

Lake County Social Services
P.O. Box 2-9000
Lower Lake, CA 95457

Main: (707) 262-0235

LASSEN COUNTY

Lassen County Welfare Dept.
P.O. Box 1359
Susanville, CA 96130

Days: (530) 251-8277
After Hours: (530) 257-6121

LOS ANGELES COUNTY

Los Angeles County Community & Senior Services
3175 West 6th Street 2-90020
Los Angeles, CA 2-90020

In-State: (800) 540-4000
Out-of-State: (213) 639-4500

MADERA COUNTY

Madera County Dept. of Public Welfare
P.O. Box 569
Madera, CA 93639

Main: (559) 675-7829
(800) 801-3999

MARIN COUNTY

Marin County Dept. of Health and Human Services
10 N. San Pedro Road, #1004
San Rafael, CA 94913

Main: (415) 499-7153
TDD: (415) 479-1601

MARIPOSA COUNTY

Mariposa County Dept. of Social Welfare
P.O. Box 7
Mariposa, CA 95338

Main: (209) 966-3030

MENDOCINO COUNTY

Mendocino County Dept. of Social Services
P.O. Box 839
Ukiah, CA 95482

Main: (707) 463-5600

MERCED COUNTY

Merced County Dept. of Human Services Agency
P.O. Box 112
Merced, CA 95341

Days: (209) 385-3104
After Hours: (209) 385-9915

MODOC COUNTY

Modoc County Dept. of Social Services
120 North Main Street
Alturas, CA 96101

Days: (530) 233-6501
After Hours: (530) 233-4416

MONO COUNTY

Mono County Dept. of Social Welfare
P.O. Box 93517
Bridgeport, CA 93517

Main: (760) 932-7755
Statewide: (800) 340-5411

MONTEREY COUNTY

Monterey County Dept. of Social Services
1000 South Main, Suite 202
Salinas, CA 93901

Main: (831) 755-4661

NAPA COUNTY

Napa County Human Services
2261 Elm St.
Napa, CA 94559

Main: (707) 253-4261

NEVADA COUNTY

Nevada County Department of Public Social Services
P.O. Box 1210
Nevada City, CA 95959

Main: (530) 265-9380

ORANGE COUNTY

Orange County Social Services Agency
P.O. Box 22006
Santa Ana, CA 92702-2006

Main: (714) 940-1000
(800) 207-4464

PLACER COUNTY

Placer County Welfare Department
11519 B Avenue
Auburn, CA 95603

Main: (530) 886-5310
(800) 488-4308

PLUMAS COUNTY

Plumas County Dept. of Social Services
P.O. Box 360
Quincy, CA 95971

Main: (530) 283-6350

RIVERSIDE COUNTY

Riverside County Dept. of Public Social Services
1020 Iowa Avenue
Riverside, CA 92507

Main: (800) 442-4918

SACRAMENTO COUNTY

Sacramento County Dept. of Social Services
4875 Broadway
Sacramento, CA 95817

Main: (916) 875-5437

SAN BENITO COUNTY

San Benito County Human Services Agency
1111 San Felipe Rd.
Hollister, CA 95023

Days: (831) 636-4190
After Hours: (831) 636-4330

SAN BERNARDINO COUNTY

San Bernardino Co. Social Services
494 North E Street
San Bernardino, CA 92401

Main: (800) 827-8724
After Hours: (909) 422-3266

SAN DIEGO COUNTY

San Diego County Department of Social Services
1261 Third Avenue
Chula Vista, CA 91911

Main: (858) 560-2191

SAN FRANCISCO COUNTY

San Francisco City and County Dept. of Human Services
P.O. Box 7988
San Francisco, CA 94120-9939

Main: (415) 558-2650
(800) 856-5553

SAN JOAQUIN COUNTY

San Joaquin County Human Services Agency
P.O. Box 201056
Stockton, CA 95201

Main: (209) 468-1333
(209) 468-1330

SAN LUIS OBISPO COUNTY

San Luis Obispo County Dept. of Social Services
P.O. Box 8119
San Luis Obispo, CA 93403-8819

Main: (805) 781-5437
(805) 834-5437

SAN MATEO COUNTY

San Mateo County Department of Health
225 West 37th Avenue
San Mateo, CA 94403

Main: (650) 595-7922
(800) 632-4615
Fax: (650) 595-7518

SANTA BARBARA COUNTY

Santa Barbara County Dept. of Social Services
234 Camino Del Remedio
Santa Barbara, CA 93110-1369

Days: (800) 367-0166
Lompoc: (805) 737-7078
After Hours: (805) 683-2724

SANTA CLARA COUNTY

Santa Clara County Department of Social Services
591 North King Road
Santa Clara, CA 95133

North: (408) 299-2071
South: (408) 683-0601

SANTA CRUZ COUNTY

Santa Cruz County Human Resources Agency
P.O. Box 1320
Santa Cruz, CA 95061

Main: (831) 454-4222
Watsonville: (831) 763-8850

SHASTA COUNTY

Shasta County Department of Social Services
P.O. Box 496005
Redding, CA 96049-6005

Main: (530) 225-5144

SIERRA COUNTY

Sierra County Department of Health and Human Services
P.O. Box 1019
Loyalton, CA 96118

24 Hours: (530) 289-3720
Bus. Hours: (530) 993-6720

SISKIYOU COUNTY

Siskiyou County Human Services	24 Hours:	(530) 842-7009
818 South Main	Bus. Hours:	(530) 841-4200
Yreka, CA 96097		

SOLANO COUNTY

Solano County Social Services	Main:	(800) 544-8696
275 Beck Ave.		
Fairfield, CA 94533		

SONOMA COUNTY

Sonoma County Social Services Department	Main:	(707) 565-4304
P.O. Box 1539		
Santa Rosa, CA 95402		

STANISLAUS COUNTY

Stanislaus County Community Service Agency	Main:	(800) 558-3665
P.O. Box 42		
Modesto, CA 95353		

SUTTER COUNTY

Sutter County Welfare Department	Main:	(530) 822-7155
P.O. Box 1599		
Yuba City, CA 95992		

TEHAMA COUNTY

Tehama County Department of Social Welfare	Main:	(800) 323-7711
		(530) 527-9416
P.O. Box 1515		
Red Bluff, CA 96080		

TRINITY COUNTY

Trinity County Welfare Department	Main:	(530) 623-1314
P.O. Box 1470		
Weaverville, CA 96093		

TULARE COUNTY

Tulare County Department of Public Social Services	Main:	(559) 730-2677
	Co. Only	(800) 331-1585
P.O. Box 671		
Visalia, CA 93279		

TUOLUMNE COUNTY

Tuolumne Department of Social Services	Days:	(209) 533-5717
20075 Cedar Road North	After Hours:	(209) 533-4357
Sonora, CA 95370		

VENTURA COUNTY

Ventura County Department of Social Services	Main:	(805) 654-3200
4651 Telephone Road, Suite 201		
Ventura, CA 93001		

YOLO COUNTY

Yolo County Department Employment & Social Services	Main:	(530) 669-2345
		(530) 669-2346
25 North Cottonwood Avenue	After Hours:	(530) 666-8920
Woodland, CA 95695		(888) 400-0022

YUBA COUNTY

Yuba County Health and Welfare Department	Main:	(530) 749-6288
6000 Lindhurst Avenue		
Marysville, CA 95901		

APPENDIX F

CALIFORNIA VICTIM/WITNESS ASSISTANCE CENTERS

For current contact information go to the Victim Compensation and Government Claims Board web site at <*http://www.boc.ca.gov/vwlist.htm*>.

ALAMEDA COUNTY
Victim/Witness Assistance Center
Alameda County District Attorney's Office
1401 Lakeside Drive, Suite 802
Oakland, CA 94612
Tel: (510) 272-6180
Fax: (510) 208-9565

ALPINE COUNTY
Victim/Witness Assistance Center
Alpine County District Attorney's Office
270 Laramie Street
P.O. Box 248
Markleeville, CA 96120
Tel: (530) 694-2971
Fax: (530) 694-2980

AMADOR COUNTY
Victim/Witness Assistance Center
Amador County District Attorney's Office
45 Summit Street
Jackson, CA 95642
Tel: (209) 223-6474
Fax: (209) 223-1953

BUTTE COUNTY
Victim/Witness Assistance Center
Butte County Probation Department
42 County Center Drive
Oroville, CA 95965
Tel: (530) 538-7340
Fax: (530) 534-8301

CALAVERAS COUNTY
Victim/Witness Assistance Center
Calaveras County District Attorney's Office
891 Mountain Ranch Road
San Andreas, CA 95249
Tel: (209) 754-6565
Fax: (209) 754-6732

COLUSA COUNTY
Victim/Witness Assistance Center
Colusa County Probation Department
532 Oak Street
Colusa, CA 95932
Tel: (530) 458-0659
Fax: (530) 458-3009

CONTRA COSTA COUNTY

Victim/Witness Assistance Center
Contra Costa County Probation Department
100 Glacier Drive, Suite A
Martinez, CA 94553

Toll Free: (800) 648-0600
Tel: (925) 646-2474
Fax: (925) 646-2739

San Pablo Victim/Witness Assistance Center
West County Office
2555 El Portal Drive
San Pablo, CA 94806

Tel: (510) 374-3272, or
(510) 374-3246
Fax: (510) 374-3441

DEL NORTE COUNTY

Victim/Witness Assistance Center
Del Norte County District Attorney's Office
450 H Street, Room 182
Crescent City, CA 95531

Tel: (707) 464-7273
Fax: (707) 464-2975

EL DORADO COUNTY

Victim/Witness Assistance Center
El Dorado County District Attorney's Office
South Lake Tahoe Office
1360 Johnson Boulevard, Suite 105
South Lake Tahoe, CA 96150

Toll Free: (800) 584-4438
Tel: (530) 573-3337
Fax: (530) 544-6413

Placerville Office
520 Main Street
Placerville, CA 95667

Toll Free: (888) 422-6492
Tel: (530) 621-6450
Fax: (530) 295-2602

FRESNO COUNTY

Victim/Witness Assistance Center
Fresno County Probation Department
2220 Tulare Street, Suite 1126
Fresno, CA 93721

Tel: (559) 488-3425
Fax: (559) 488-3826

GLENN COUNTY

Victim/Witness Assistance Center
HRA Community Action Division
420 East Laurel Street
Willows, CA 95988

Toll Free: (800) 287-8711
Tel: (530) 934-6510
Fax: (530) 934-6650

HUMBOLDT COUNTY

Victim/Witness Assistance Center
Humboldt County District Attorney's Office
712 Fourth Street
Eureka, CA 95501

Tel: (707) 445-7417
Fax: (707) 445-7490

IMPERIAL COUNTY

Victim/Witness Assistance Center
Imperial County Probation Department
217 South Tenth, Building A
El Centro, CA 92243

Tel: (760) 336-3930
Fax: (760) 353-3292

INYO COUNTY

Victim/Witness Assistance Center
301 West Line Street, Suite C
Bishop, CA 93514

Tel: (760) 873-6669
Fax: (760) 873-8359

Inyo County District Attorney's Office
P.O. Drawer D
Independence, CA 93526

Tel: (760) 878-0282
Fax: (760) 878-2383

KERN COUNTY

Victim/Witness Assistance Center
Kern County Probation Department
1415 Truxtun Avenue, 6th Floor, Room 603
Bakersfield, CA 93301

Tel: (661) 868-4535
Fax: (661) 868-4586

KINGS COUNTY

Victim/Witness Assistance Center
Kings County Probation Department
Kings County Government Center
1400 West Lacey Boulevard
Hanford, CA 93230

Tel: (559) 582-3211 ext. 2640
Fax: (559) 584-7038

LAKE COUNTY

Victim/Witness Assistance Center
Lake County District Attorney's Office
420 Second Street
Lakeport, CA 95453

Tel: (707) 262-4282
Fax: (707) 262-5851

LASSEN COUNTY

Victim/Witness Assistance Center
Lassen County District Attorney's Office
Courthouse
220 South Lassen Street, Suite 8
Susanville, CA 96130

Tel: (530) 251-8283
Fax: (530) 257-2-9009

LOS ANGELES COUNTY

Victim/Witness Assistance Center
Los Angeles County District Attorney's Office
3204 Rosemead Boulevard, Suite E
El Monte, CA 91731

Tel: (626) 927-2525
Fax: (626) 569-9541

Central Victim/Witness Office
210 West Temple, No. 12-514
Los Angeles, CA 2-90012

Toll free: (800) 773-7540
Tel: (213) 774-7499
Fax: (213) 625-8104

El Monte Victim/Witness Office
3220 North Rosemead Boulevard
El Monte, CA 91731

Toll Free: (800) 492-5944
Tel: (626) 572-6366
Fax:(626) 280-0817

El Monte Victim/Witness
11234 East Valley Boulevard
El Monte, CA 91731

Tel: (626) 350-4583
Fax: (626) 442-6543

Sexual Crimes/Child Abuse Unit
Hall of Records
320 West Temple Street, Room 740
Los Angeles, CA 2-90012

Tel: (213) 974-3801
Fax: (213) 625-2810

Carson Sheriff
21356 South Avalon Boulevard
Carson, CA 90745

Tel: (310) 830-8376
Fax: (310) 847-8368

Compton Courthouse
200 West Compton Boulevard, Room 700
Compton, CA 90220

Tel: (310) 603-7579, or
(310) 603-7574, or
(310) 603-7127
Fax: (310) 603-0493

Statutory Rape Program Hall of Records 320 West Temple Street, No. 740 Los Angeles, CA 2-90012	Tel: (213) 974-3908 Fax: (213) 625-2810
Inglewood Courthouse One Regent Street, Room 405 Inglewood, CA 90301	Tel: (310) 419-6764, or (310) 419-5175 Fax: (310) 674-7839
Long Beach Courthouse 415 West Ocean Boulevard, Room 305 Long Beach, CA 90802	Tel: (562) 491-6347, or (562) 491-6310 Fax: (562) 436-9849
Santa Monica Courthouse 1725 Main Street, Room 228 Santa Monica, CA 90401	Tel: (310) 260-3678 Fax: (310) 458-6518
Torrance Courthouse 825 Maple Avenue Torrance, CA 90503	Tel: (310) 222-3599 Fax: (310) 783-1684
Antelope Valley Courthouse 1110 West Avenue J Lancaster, CA 93534	Tel: (661) 945-6464 Fax: (661) 945-6179
Hollywood LAPD 1358 North Wilcox Avenue Los Angeles, CA 2-90028	Tel: (323) 871-1184 Fax: (213) 485-8891
Industry Sheriff 150 North Hudson Avenue City of Industry, CA 91744	Tel: (626) 934-3004 Fax: (626) 333-1895
Pasadena Courthouse 300 East Walnut Street, Room 107 Pasadena, CA 91101	Tel: (626) 356-5714, or (626) 356-5715 Fax: (626) 796-3176
Pomona Courthouse 400 Civic Center Drive, Room 201 Pomona, CA 91766	Tel: (909) 620-3381, or (909) 620-3382 Fax: (909) 629-6876

San Fernando Area
2-900 – 3rd Street, Room G14
San Fernando, CA 91340
Tel: (818) 898-2406
Fax: (818) 898-2743

Temple City Sheriff
8838 East Las Tunas Drive
Temple City, CA 91780
Tel: (626) 292-3333
Fax: (626) 287-7353

Van Nuys Courthouse
6230 Sylmar Avenue, 5th Floor
Van Nuys, CA 91401
Tel: (818) 374-3075
Fax: (818) 782-5349

Central LAPD
251 East Sixth Street
Los Angeles, CA 2-90014
Tel: (213) 627-1619
Fax: (213) 847-2956

East Los Angeles Courthouse
214 South Fetterly Avenue, Room 201
Los Angeles, CA 2-90022
Tel: (323) 780-2045
Fax: (323) 269-4869

Huntington Park Area Office
2958 East Florence Avenue
Huntington Park, CA 90255
Tel: (323) 586-6337
Fax: (323) 584-9055

Lakewood Sheriff
5130 North Clark Avenue
Lakewood, CA 90712
Tel: (562) 920-5156
Fax: (562) 867-4712

Norwalk Courthouse
12720 Norwalk Boulevard, Room 201
Norwalk, CA 90650
Tel: (562) 807-7230
Fax: (562) 929-7626

Rampart LAPD
303 South Union
Los Angeles, CA 2-90057
Tel: (213) 483-6731
Fax: (213) 207-2108

Southeast LAPD
145 West 108th Street
Los Angeles, CA 2-90061
Tel: (323) 754-8064
Fax: (323) 485-8340

Southwest LAPD
1546 Martin Luther King Boulevard
Los Angeles, CA 2-90062

Tel: (323) 296-8645
Fax: (323) 473-6757

Eastlake Juvenile Office
1601 Eastlake Avenue, Room 132
Los Angeles, CA 2-90033

Tel: (323) 226-8918
Fax: (323) 223 6248

Family Violence Division
Criminal Courts Building
210 W. Temple Street, Room 603
Los Angeles, CA 2-90012

Tel: (213) 974-7410, or
(213) 974-3879
Fax: (213) 217-4992

Stalking & Threat Management Team
Hall of Records
320 W. Temple Street, Room 780-41
Los Angeles, CA 2-90012

Tel: (213) 893-0896
Fax: (213) 626-2758

Whittier Branch Office
7339 S. Painter Ave., Room 200
Whittier, CA 90602

Tel: (562) 907-3189
Fax: (562) 696-9631

Child Abuse Crisis Center
Harbor-UCLA Medical Center
1000 W. Carson St.
Box 460 Trailer N-26
Torrance, CA 90509

Tel: (310) 222-1208
Fax: (310) 320-7849

East L.A. Sheriff
5019 E. Third Street
Los Angeles, CA 2-90022

Tel: (323) 981-5024
Fax: (323) 267-0637

<u>LOS ANGELES CITY</u> (Subgrant to Los Angeles County Victim/Witness)

Victim/Witness Assistant Center
Los Angeles City Attorney's Office
312 South Hill Street, Third Floor
Los Angeles, CA 2-90013
Tel: (213) 485-6976
Fax: (213) 847-8667

Victim Assistance Program
Korean Outreach Project
312 South Hill Street, Second Floor
Los Angeles, CA 2-90013
Tel: (213) 485-9889
Fax: (213) 847-8667

North Hollywood Station LAPD
Victim Assistance Program
11640 Burbank Boulevard
North Hollywood, CA 91601
Tel: (818) 623-4056
Fax: (818) 623-4121

Victim Assistance Program
San Pedro City Hall
638 S. Beacon St., Room 326
San Pedro, CA 90731
Tel: (310) 732-4611
Fax: (310) 732-4618

Victim Assistance Program
Van Nuys City Hall
14410 Sylvan Street, Room 117
Van Nuys, CA 91401
Tel: (818) 756-8488
Fax: (818) 756-9444

Wilshire Area Station LAPD
Victim Assistance Program
4861 Venice Boulevard
Los Angeles, CA 2-90019
Tel: (213) 847-1991
Fax: (213) 847-0668

West Los Angeles Station LAPD
Victim Assistance Program
1663 Butler Avenue
West Los Angeles, CA 2-90025
Tel: (310) 575-8441
Fax: (310) 575-6710

Newton Area Station LAPD
Victim Assistance Program
3400 South Central Avenue
Los Angeles, CA 2-90011

Tel: (323) 846-5374
Fax: (323) 846-6586

77th Street Area Station LAPD
Victim Assistance Program
7600 South Broadway
Los Angeles, CA 2-90003

Tel: (213) 485-8848
Fax: (213) 847-0667

Hollenbeck Area Station LAPD
Victim Assistance Program
2111 East First Street
Los Angeles, CA 2-90033

Tel: (323) 526-3190
Fax: (323) 485-8401

MADERA COUNTY

Victim/Witness Assistance Center
Madera County Community Action Committee, Inc.
1200 West Maple Street, Suite C
Madera, CA 93637

Tel: (559) 661-1000
Fax: (559) 661-8389

MARIN COUNTY

Victim/Witness Assistance Center
Marin County District Attorney's Office
3501 Civic Center Drive, Room 130
San Rafael, CA 94903

Tel: (415) 499-6450
Fax: (415) 499-3719

MARIPOSA COUNTY

Victim/Witness Assistance Center
Mariposa County District Attorney's Office
P.O. Box 730
Mariposa, California 95338

Tel: (209) 742-7441
Fax: (209) 742-5780

MENDOCINO COUNTY

Victim/Witness Assistance Center
Mendocino County District Attorney's Office
Courthouse, Room 10
100 North State Street
P.O. Box 144
Ukiah, CA 95482

Tel: (707) 463-4218
Fax: (707) 468-3371

MERCED COUNTY
Victim/Witness Assistance Center
Merced County District Attorney's Office
658 W. 20th St.
Merced, CA 95340
Tel: (209) 725-3515
Fax: (209) 725-3669

MODOC COUNTY
Victim/Witness Assistance Center
Modoc County District Attorney's Office
204 South Court Street
Alturas, CA 96101
Tel: (530) 233-3311
Fax: (530) 233-5024

MONO COUNTY
Victim/Witness Assistance Center
452 Old Mammoth Road, Third Floor
P.O. Box 2053
Mammoth Lakes, CA 93546
Tel: (760) 924-1710
Fax: (760) 924-1711

Bridgeport Victim/Witness Office
P.O. Box 617
Bridgeport, CA 93517
Tel: (760) 932-5550
Fax: (760) 924-1711

MONTEREY COUNTY
Victim/Witness Assistance Center
Monterey County District Attorney's Office
240 Church Street #101
P.O. Box 1311
Salinas, CA 93901
Tel: (831) 755-5272
Fax: (831) 796-6448

NAPA COUNTY
Victim/Witness Assistance Center
Napa County Volunteer Center, Inc.
1820 Jefferson Street
Napa, CA 94559
Tel: (707) 252-6222
Fax: (707) 226-5179

NEVADA COUNTY
Victim/Witness Assistance Center
Nevada County Probation Department
109 ½ North Pine Street
Nevada City, CA 95959
Tel: (530) 265-1246, or
(530) 265-1331
Fax: (530) 265-6304

ORANGE COUNTY

Victim/Witness Assistance Administrative Center
Community Service Programs, Inc.
1821 East Dyer, Suite 200
Santa Ana, CA 92705-5700
Tel: (949) 975-0244
Fax: (949) 975-0250

Superior Court
Central Justice Center
700 Civic Center Drive West
P.O. Box 1994
Santa Ana, CA 92702
Tel: (714) 834-4350
Fax: (714) 834-2688

North Justice Center
1275 North Berkeley Avenue
Fullerton, CA 92635
Tel: (714) 773-4575
Fax: (714) 441-3575

Harbor Justice Center-Laguna Niguel
30143 Crown Valley Parkway
Laguna Niguel, CA 92677
Tel: (949) 249-5037
Fax: (949) 249-5100

West Justice Center
8141 13th Street
Westminster, CA 92683
Tel: (714) 896-7188
Fax (714) 896-7526

Harbor Justice Center-Newport Beach
4601 Jamboree Boulevard, Suite 103
Newport Beach, CA 92660
Tel: (949) 476-4855
Fax: (949) 476-4623

Lamoreaux Justice Center
301 The City Drive
Orange, CA 92668
Tel: (714) 935-7074
Fax: (714) 935-6341

PLACER COUNTY

Victim/Witness Assistance Program
Placer County District Attorney's Office
11562 B Avenue
Auburn, CA 95603
Tel: (530) 889-7021
Fax: (530) 886-2294

PLUMAS COUNTY

Victim/Witness Assistance Center
Plumas County Sheriff's Department
75 Court Street, Suite A
Quincy, CA 95971

Tel: (530) 283-6285
Fax: (530) 283-6226

RIVERSIDE COUNTY

Victim/Witness Assistance Center
Riverside County District Attorney's Office
4075 Main Street, First Floor
Riverside, CA 92501

Tel: (909) 955-5450
Fax: (909) 955-5640

Banning Victim/Witness Office
Western Riverside County
135 North Alessandro, Room 205
Banning, CA 92220

Tel: (909) 849-6218
Fax: (909) 922-7135

Blythe Victim/Witness Office
Eastern Riverside County
225 North Broadway
Blythe, CA 92225

Tel: (935) 921-7878
Fax: (935) 921-7849

Southwest Justice Center
30755-D Auld Road
Murrieta, CA 92563

Tel: (909) 304-5500
Fax: (909) 304-5503

Indio Victim/Witness Office
Eastern Riverside County
82-675 Highway 111, Fourth Floor
Indio, CA 92201

Tel: (760) 863-8408
Fax: (760) 863-7640, or
(760) 863-8987

Riverside Juvenile Office
Western Riverside County
9991 County Farm Road
Riverside, CA 92503

Tel: (909) 358-4152
Fax: (909) 358-4497

Corona Police Department
515 So. Corona Mall
Corona, CA 92882

Tel: (909) 739-4872
Fax: (909) 279-3599

SACRAMENTO COUNTY

Victim/Witness Assistance Center
Sacramento County District Attorney's Office
901 G Street
P.O. Box 749
Sacramento, CA 95814

Tel: (916) 874-5701
Fax: (916) 874-5271

SAN BENITO COUNTY

Victim/Witness Assistance Center
San Benito County District Attorney's Office
419 Fourth Street
Hollister, CA 95023-3801

Tel: (831) 637-8244
Fax: (831) 636-4126

SAN BERNARDINO COUNTY

Victim/Witness Assistance Center
San Bernardino County District Attorney's Office
316 North Mountain View Avenue, 3rd Floor
San Bernardino, CA 92415

Tel: (909) 387-6540, or
(909) 387-6384
Fax: (909) 387-6313

San Bernardino Juvenile Division
2-900 East Gilbert Street
San Bernardino, CA 92415

Tel: (909) 387-8665
Fax: (909) 387-6980

San Bernardino Police Department
710 North D Street
San Bernardino, CA 92401

Tel: (909) 388-42-900
Fax: (909) 388-4843

Colton Police Department
650 North La Cadena Drive
Colton, CA 92324

Tel: (909) 370-5164
Fax: (909) 370-5158

Fontana Victim/Witness Center
17830 Arrow Boulevard
Fontana, CA 92335

Tel: (909) 356-6406
Fax: (909) 356-6779

Ontario Police Department
200 North Cherry Avenue
Ontario, CA 91764
Tel: (909) 395-2713
Fax: (909) 395-2730

Rancho Cucamonga Victim/WitnessOffice
8303 North Haven Avenue, 4th Floor
Rancho Cucamonga, California 91730
Tel: (909) 945-4241
Fax: (909) 945-4035

Victorville Victim/Witness Office
14455 Civic Drive
Victorville, California 92392
Tel: (760) 243-8619
Fax: (760) 243-8619

Barstow Victim/Witness Office
235 East Mountain View
Barstow, CA 92311
Tel: (760) 256-4802
Fax: (760) 256-4869

Joshua Tree Victim/Witness Center
6527 White Feather Road
Joshua Tree, CA 92252
Tel: (760) 366-5740
Fax: (760) 366-4126

SAN DIEGO COUNTY

Victim/Witness Assistance Center
San Diego County District Attorney's Office
330 West Broadway, Suite 800
P.O. Box 121011
San Diego, CA 92101
Tel: (619) 531-4041
Fax: (619) 685-6521

Chula Vista Victim/Witness Office
500 Third Avenue
Chula Vista, CA 92010
Tel: (619) 691-4539
Fax: (619) 691-4459

El Cajon Victim/Witness Office
250 East Main Street, 5th Floor
El Cajon, CA 92020
Tel: (619) 441-4538
Fax: (619) 441-4095

Vista Victim/Witness Office
325 South Melrose, Suite 5000
Vista, CA 92083
Tel: (760) 806-4079
Fax: (760) 806-4162, or
(760) 806-4163

Juvenile Victim/Witness Office
2851 Meadowlark Drive
San Diego, CA 92123

Tel: (858) 694-4595
Fax: (858) 694-4774

San Diego Police Department
1401 Broadway
San Diego, California 92101

Tel: (619) 531-2772, or
(619) 531-2773
Fax: (619) 525-8433

SAN FRANCISCO COUNTY AND CITY

Victim/Witness Assistance Center
San Francisco County District Attorney's Office
850 Bryant Street, Room 320
San Francisco, CA 94103

Tel: (415) 553-9044
Fax: (415) 553-1034

SAN JOAQUIN COUNTY

Victim/Witness Assistance Center
San Joaquin County District Attorney's Office
222 East Weber Avenue, Room 245
Stockton, CA 95202

Tel: (209) 468-2500
Fax: (209) 468-2521

SAN LUIS OBISPO COUNTY

Victim/Witness Assistance Center
San Luis Obispo County District Attorney's Office
County Government Center, Room 121
San Luis Obispo, CA 93408

Toll Free: (866) 781-5821
Tel: (805) 781-5822
Fax: (805) 781-5828

SAN MATEO COUNTY

Victim/Witness Assistance Center
San Mateo County District Attorney's Office
1024 Mission Road
South San Francisco, CA 94080

Tel: (650) 877-5492
Fax: (650) 877-7001

SANTA BARBARA COUNTY

Victim/Witness Assistance Center
Santa Barbara County District Attorney's Office
118 East Figueroa Street
Santa Barbara, CA 93101
Tel: (805) 568-2408
Fax: (805) 568-2453

Santa Maria Victim/Witness Office
312 East Cook Street
Santa Maria, CA 93454
Tel: (805) 346-7529
Fax: (805) 346-7585

Lompoc Victim/Witness Office
115 Civil Plaza Center
Lompoc, CA
Tel: (805) 737-7910
Fax: (805) 737-7732

SANTA CLARA COUNTY

Santa Clara County Victim/Witness
Assistance Center
National Conference for Community and Justice
777 North First Street, Suite 220
San Jose, CA 95112
Tel: (408) 295-2656
Fax: (408) 295-2045

SANTA CRUZ COUNTY

Victim/Witness Assistance Center
Santa Cruz County District Attorney's Office
701 Ocean Street, Room 200
Santa Cruz, CA 95060
Tel: (831) 454-2010, or
(831) 454-2623
Fax: (831) 454-2612

SHASTA COUNTY

Victim/Witness Assistance Center
Shasta County District Attorney's Office
1525 Court Street
Redding, CA 96001
Tel: (530) 225-5220, or
(530) 225-5195
Fax: (530) 245-6334

SIERRA COUNTY

Victim/Witness Assistance Center
Sierra County Probation Department
604B Main Street
P.O. Box 886
Loyalton, CA 96118
Tel: (530) 993-4617
Fax: (530) 993-4327

SISKIYOU COUNTY

Victim/Witness Assistance Center
Siskiyou County District Attorney's Office
311 4th Street
P.O. Box 986
Yreka, CA 96097

Tel: (530) 842-8229
Fax: (530) 842-8222

Tulelake Office
298 Street
P.O. Box 790
Tulelake, CA 96134

Tel: (530) 667-2147
Fax: (530) 667-2822

SOLANO COUNTY

Victim/Witness Assistance Center
Solano County District Attorney's Office
Hall of Justice
600 Union Avenue
Fairfield, CA 94533

Tel: (707) 421-6844
Fax: (707) 421-7986

Solano Victim/Witness Office
Solano County Justice Building
321 Tuolumne Street
Vallejo, California 94590

Tel: (707) 554-5400
Fax: (707) 554-5654

SONOMA COUNTY

Vacant, Project Coordinator
Victim/Witness Assistance Center
Sonoma County District Attorney's Office
P.O. Box 6023
Santa Rosa, CA 95406

Tel: (707) 565-8250
Fax: (707) 565-8262

STANISLAUS COUNTY

Victim/Witness Assistance Center
Stanislaus County District Attorney's Office
800 11th Street, Room 200
P.O. Box 442
Modesto, CA 95354

Tel: (209) 525-5541
Fax: (209) 525-5551

SUTTER COUNTY

Victim/Witness Assistance Center
Sutter County District Attorney's Office
204 C Street
P.O. Box 1555
Yuba City, CA 95991

Tel: (530) 822-7345
Fax: (530) 822-7464

TEHAMA COUNTY

Victim/Witness Assistance Center
Tehama County District Attorney's Office
444 Oak Street
P.O. Box 519
Red Bluff, CA 96080

Tel: (530) 527-4296
Fax: (530) 527-4735

TRINITY COUNTY

Victim/Witness Assistance Center
Trinity County Probation Department
333 Tom Bell Road
P.O. Box 158
Weaverville, CA 96093

Tel: (530) 623-1204
Fax: (530) 623-1237

TULARE COUNTY

Victim/Witness Assistance Center
Tulare County District Attorney's Office
221 South Mooney Boulevard #264
Visalia, CA 93291

Tel: (559) 733-6754
Fax: (559) 730-2931

TUOLUMNE COUNTY

Victim/Witness Assistance Center
Tuolumne County District Attorney's Office
423 North Washington Street
Sonora, CA 95370

Tel: (209) 588-5440
Fax: (209) 588-5455

VENTURA COUNTY

Victim/Witness Assistance Center
Ventura County District Attorney's Office
800 South Victoria Avenue, Room 311
Ventura, CA 93009

Tel: (805) 654-3622
Fax: (805) 662-6523

YOLO COUNTY

Victim/Witness Assistance Center
Yolo County District Attorney's Office
301 Second Street
Woodland, CA 95695

Tel: (530) 666-8187
Fax: (530) 666-8185

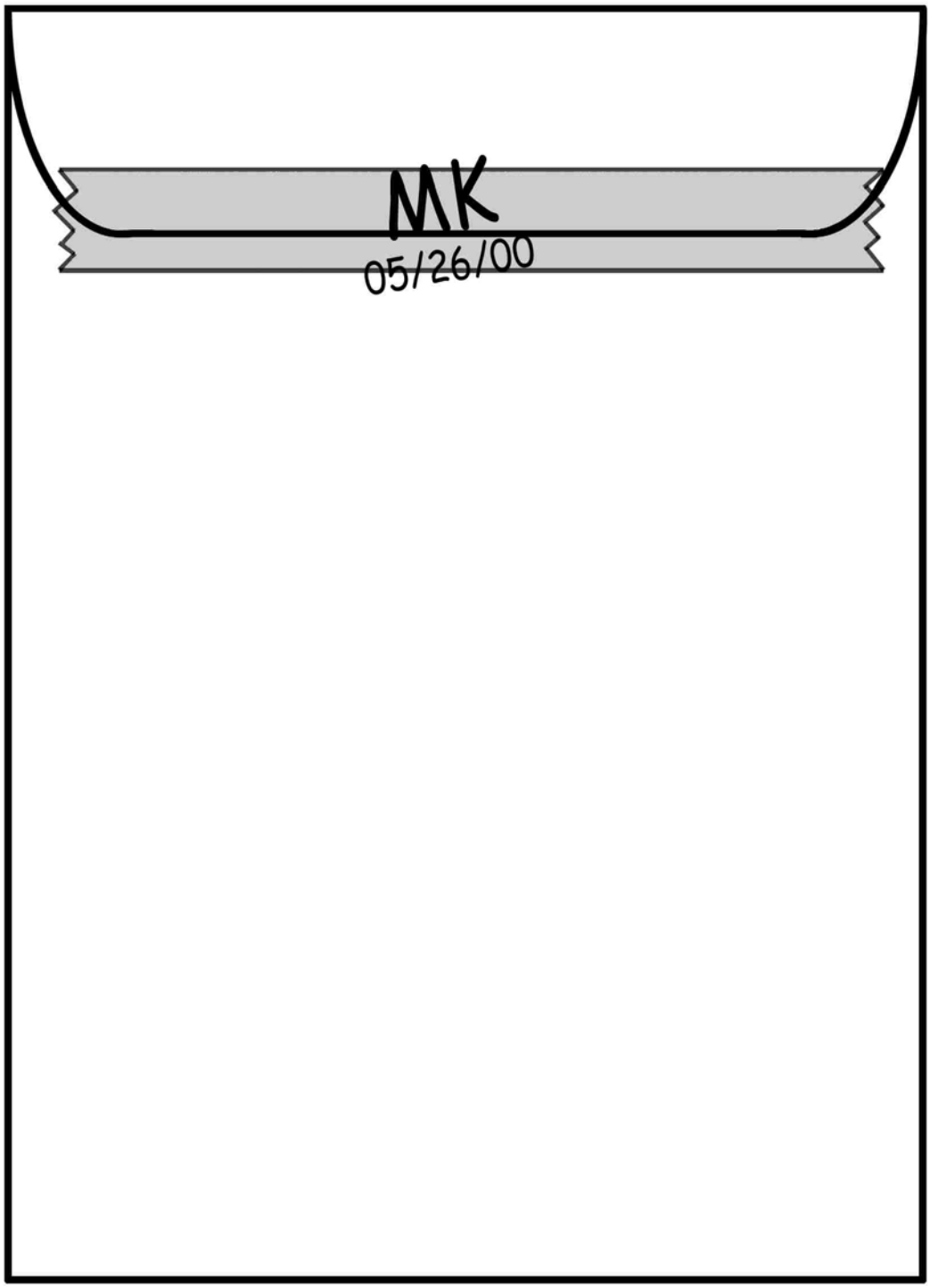
YUBA COUNTY

Victim/Witness Assistance Center
Yuba County Probation Department
4240 Dan Avenue
Marysville, CA 95901

Tel: (530) 741-6275
Fax: (530) 749-7913

APPENDIX G

EXAMPLE OF SEALED EVIDENCE ENVELOPE



Note: Sign and date over the seal.

APPENDIX H

CHAIN OF CUSTODY FORM

CALIFORNIA COUNTY
Laboratory of Forensic Sciences

EVIDENCE COLLECTION KIT

FOR HOSPITAL PERSONNEL
(Please print)

Name of Patient: _____ **Date of Birth:** _____ ☐ **Female** ☐ **Male**

Name of Examiner: _____

Name of Hospital: _____ **Date of Exam:** _____

Law Enforcement Agency: _____

Agency Case No.: _____

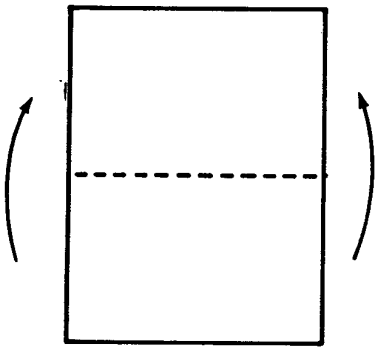
AFFIX BIOHAZARD LABEL HERE AFTER SPECIMEN COLLECTION

CHAIN OF CUSTODY

FROM: (Print Name and Sign)	**TO:** (Print Name and Sign)	**DATE**	**TIME**

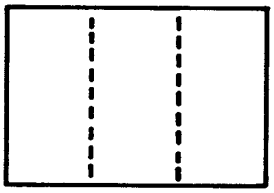
APPENDIX I

HOW TO MAKE A BINDLE



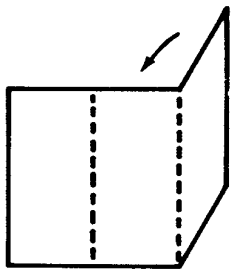
1

Fold the paper in half.



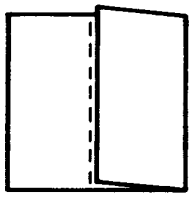
2

Fold the half-sized paper into thirds.



3

Fold over the right flap.



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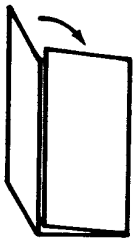
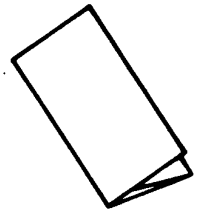


5

Fold over the left flap.



6

7

Fold in half. Seal the open end of the bindle, not the folded end. Initial the tape prior to sealing.

APPENDIX J

CalEMA 2-900 FORM AND INSTRUCTIONS

The CalEMA 2-900 form can be downloaded from these websites:

California Emergency Management Agency -- **www.calema.ca.gov**
Look for Criminal Justice Programs Division. Click on the appropriate document in Publications and Brochures to view document list.

California Clinical Forensic Medical Training Center at University of California, Davis -- **www.ccfmtc.org.**

State of California
California Emergency Management Agency

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalEMA 2-900

For more information or assistance in completing the CalEMA 2-900, please contact University of California, Davis California Clinical Forensic Medical Training Center at: (888) 705-4141 or www.ccfmtc.org

Available at: **www.calema.ca.gov**

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
California Emergency Management Agency
CalEMA 2-900

Confidential Document: Restricted Release | **Patient Identification:** **Date:**

A. GENERAL INFORMATION

☐ See Patient Label/Registration Face Sheet

1. Name of Medical Facility Where Exam Performed	Facility Address	2. Date of Exam	Time of Exam

3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone

4. Street Address	City	County	State	Zip Code

5. Age	Date of Birth	Gender	Ethnicity
		☐ Female ☐ Male	

6. Interpreter Used: ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services

☐ Contracted Agency, specify: _____

☐ Family ☐ Friend ☐ Other, specify: _____

7. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ **Gender** ☐ Female ☐ Male **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ **Gender** ☐ Female ☐ Male **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

9. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT

Mandatory Child Abuse/Neglect Report made to both Law Enforcement and CPS Agencies (Pursuant to Penal Code §11166):

☐ Law Enforcement ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:	Name of Agency	Telephone	Date
☐ Child Protective Services ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:	Name of Agency	Telephone	Date

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name **ID Number** **Agency** ☐ **Unknown**

Child Protective Services _____

and/or

Law Enforcement Officer _____

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION (See instructions)

☐ Law Enforcement Authorized ☐ CPS Authorized ☐ Placed in protective custody ☐ Physician authority pursuant to state law ☐ Parent/Guardian consent

E. DISTRIBUTION OF CalEMA 2-900 (Check all that apply)

☐ Law Enforcement Agency (original) ☐ Hand Delivered ☐ Mailed ☐ Faxed	☐ Child Protective Services (copy) ☐ Hand Delivered ☐ Mailed ☐ Faxed
☐ Crime Laboratory (copy included with evidence)	☐ Medical Facility Records (copy)

F. PATIENT HISTORY

1. Name of Person(s) Providing History	Relationship to Patient
2. Child Accompanied to Facility By	**Relationship to Patient**

Patient Identification: **Date:**

3. History of Present Illness ☐ **See dictation for additional information.** ☐ **N/A**

If dictating, provide brief 2-3 sentence handwritten summary. Print or write legibly. Include date, time or timeframe, place of incident, and initial reporting party. Distinguish statements made by child in quotation marks from those statements made by other historians.

G. PAST MEDICAL HISTORY

	Yes	No	Unknown	Describe
Birth History (if applicable)	☐	☐	☐	
Physical Abuse History	☐	☐	☐	
Sexual Abuse History	☐	☐	☐	
Neglect History	☐	☐	☐	
Emotional Abuse History	☐	☐	☐	
Domestic Violence Exposure	☐	☐	☐	
Alcohol/Drug Exposure ☐ Prenatal ☐ Postnatal ☐ Alcohol ☐ Drug	☐	☐	☐	Specify types of drugs if known, and collect urine toxicology up to 96 hours after ingestion:
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant Illness/Injury	☐	☐	☐	
Any pertinent medical condition(s) that may affect the interpretation of findings?	☐	☐	☐	
Allergies	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations Up To Date	☐	☐	☐	
Disabilities	☐	☐	☐	(Specify):
Growth & Development ☐ WNL ☐ ABN ☐ Unknown	☐	☐	☐	

H. REVIEW OF SYSTEMS ☐ Negative except as noted below

☐ See dictation for additional information ☐ N/A

I. NAME OF PERSON TAKING HISTORY (Print Name)	Signature	Telephone	Date

J. GENERAL PHYSICAL EXAMINATION

1. Temperature	Pulse	Respiration	Blood Pressure

2. Height (cm or in)	(%)	Weight (kg or lb)	(%)	Children under 2: (HC)	(%)

Patient Identification: **Date:**

3. General physical appearance, demeanor, and level of physical discomfort/pain. Provide brief handwritten summary even if dictating. ☐ See dictation for additional information. ☐ N/A

4. Record results of physical examination.

	WNL	ABN	Not Examined	See Body Diagram	Describe Abnormal Findings. ☐ N/A ☐ See dictation for additional information
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/Pharynx					
Teeth					
Neck					
Lungs					
Chest					
Heart					
Abdomen					
Back					
Buttocks					
Extremities					
Neurological					
Genitalia					

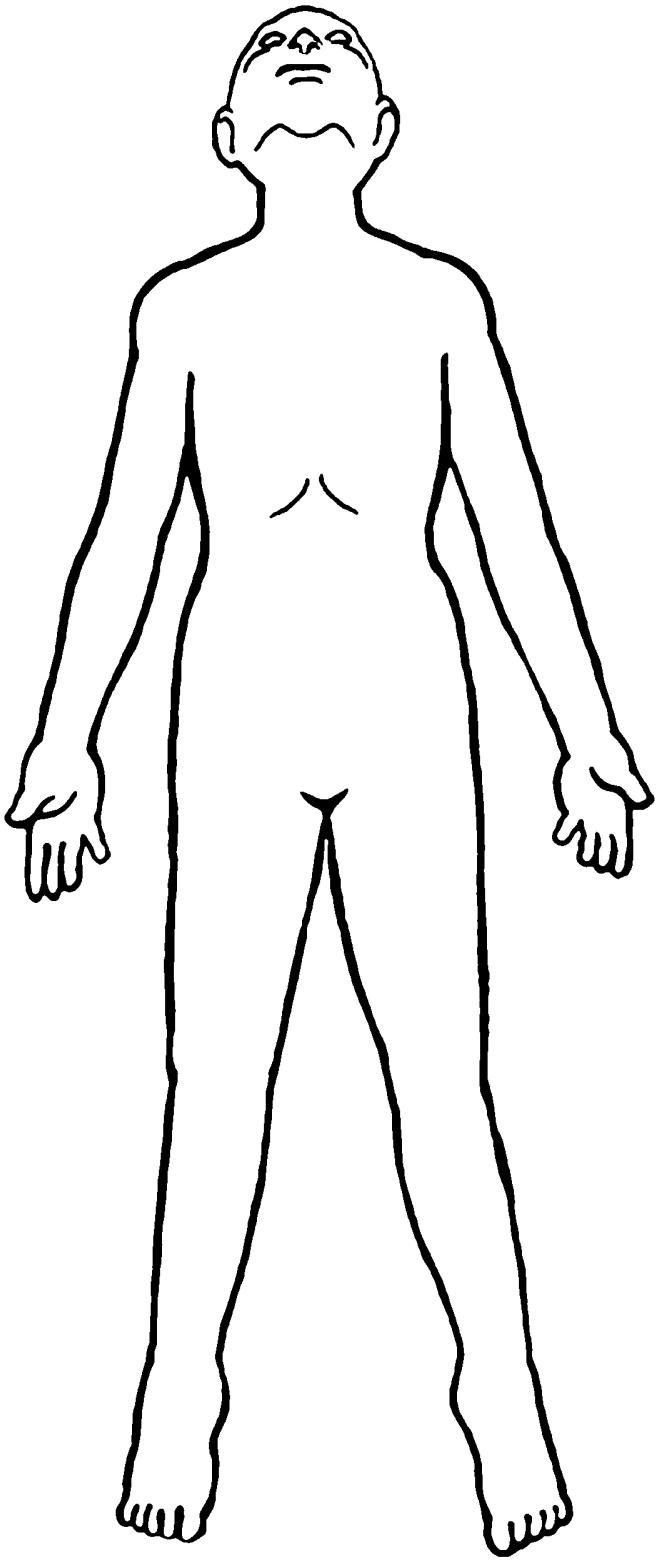
5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from CalEMA 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or CalEMA 925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document findings and attach to this form.

J. GENERAL PHYSICAL EXAMINATION (continued)

6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

A



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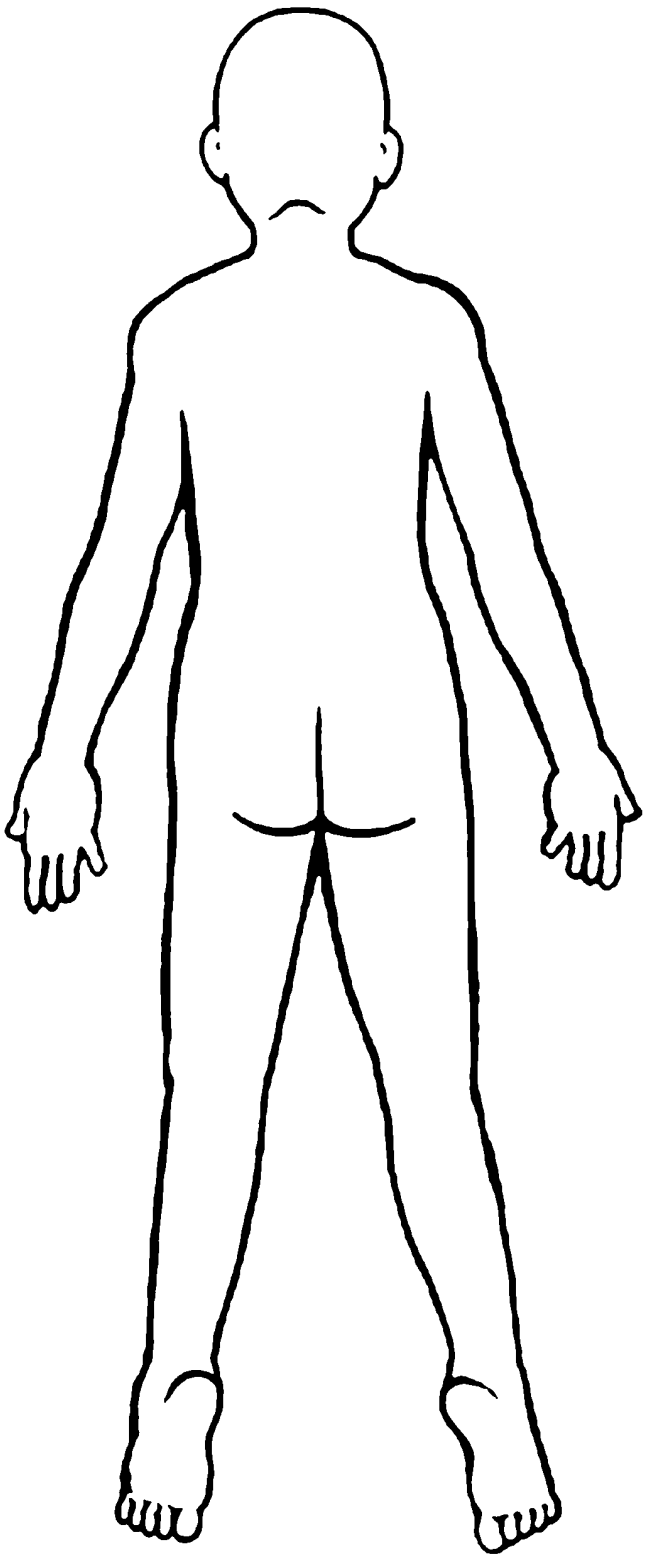
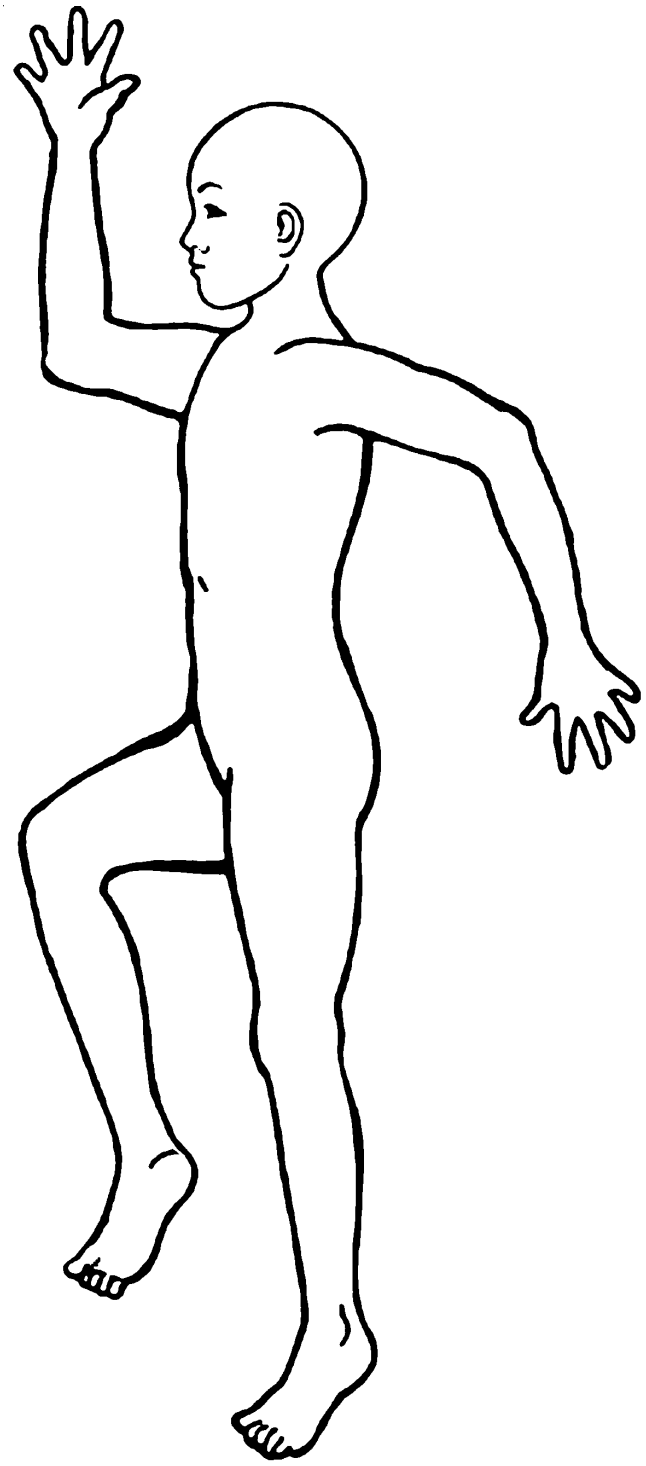


J. GENERAL PHYSICAL EXAMINATION (continued)

6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

C



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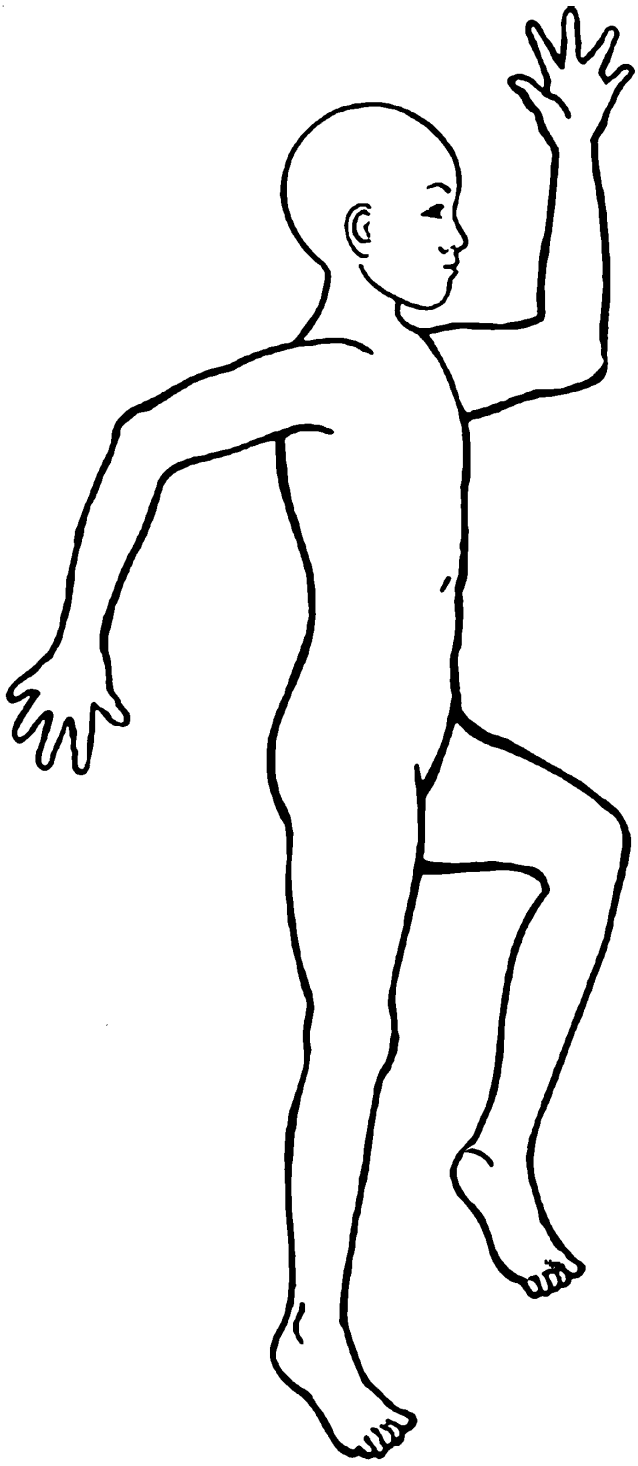
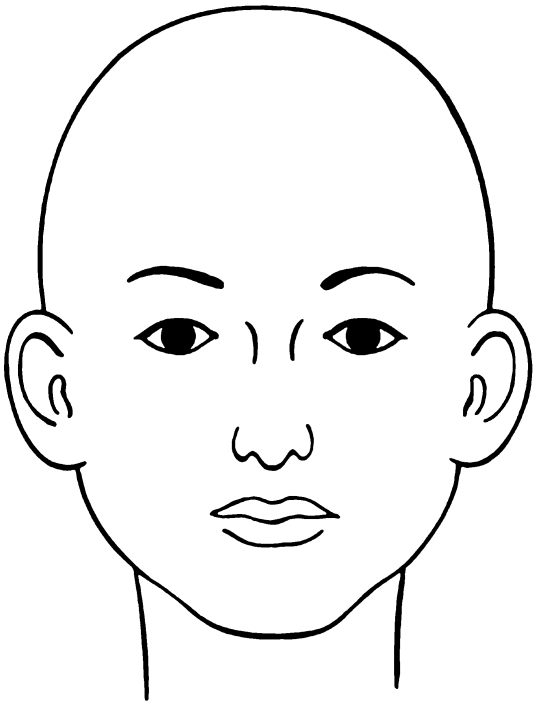


J. GENERAL PHYSICAL EXAMINATION (continued)

7. Examine the face, head, ears, hair, scalp, neck, and mouth for

Patient Identification: **Date:**

E



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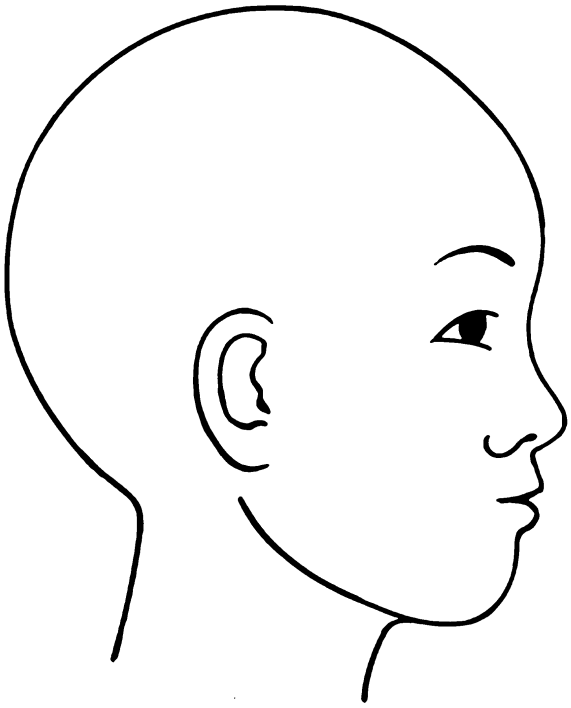

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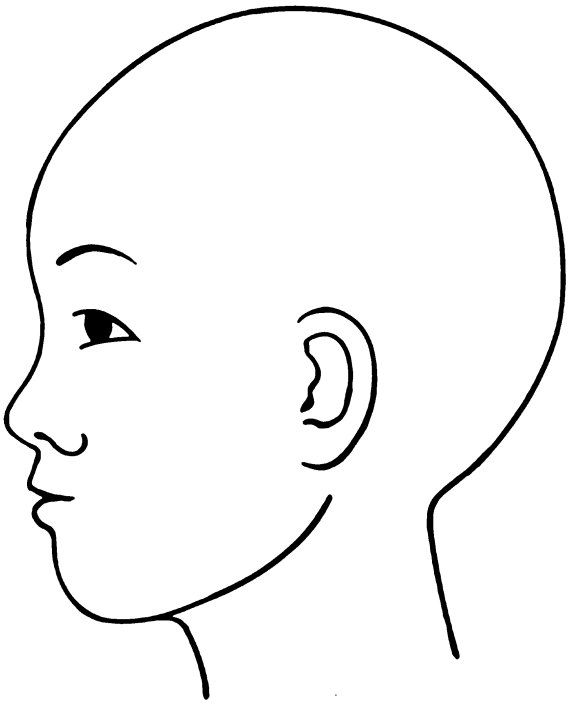

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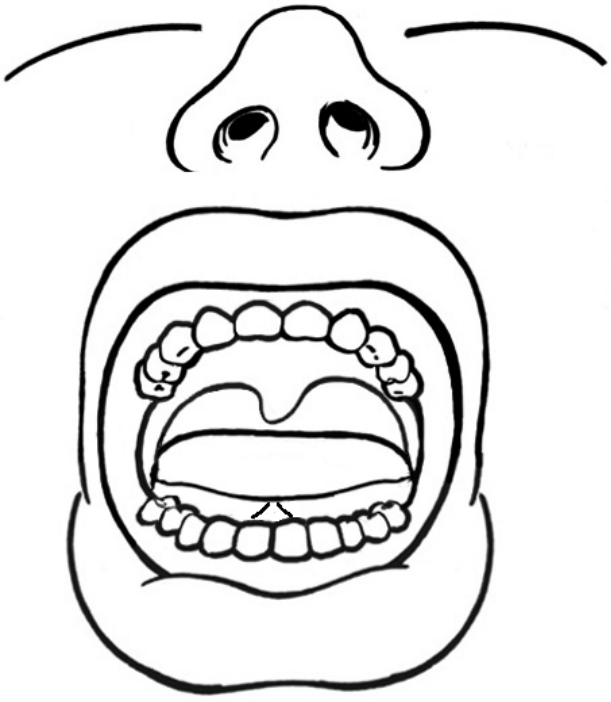

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes ☐ N/A

Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Control swabs	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Matted hair cuttings	☐	☐	☐	

Other types, describe: _____

L. TOXICOLOGY SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

M. REFERENCE SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood (lavender top tube)	☐	☐	☐		
Blood card (optional)	☐	☐	☐		
Buccal swabs (optional)	☐	☐	☐		
Saliva swabs	☐	☐	☐		

N. DIAGNOSTIC STUDIES ☐ Refer to dictation

1. Laboratory:

	WNL	ABN	N/A	Pending	Results
☐ CBC	☐	☐	☐	☐	
☐ Platelets	☐	☐	☐	☐	
☐ INR, PTT, PT	☐	☐	☐	☐	
☐ SGOT, SGPT	☐	☐	☐	☐	
☐ Urinalysis	☐	☐	☐	☐	
☐ Toxicology Screen	☐	☐	☐	☐	
☐ Other	☐	☐	☐	☐	

2. Diagnostic Imaging

	WNL	ABN	N/A	Preliminary Reading	Final Report
☐ Skeletal Survey	☐	☐	☐	☐	☐
☐ CT Scan	☐	☐	☐	☐	☐
☐ M R I	☐	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐	☐

Describe:

3. Exam Performed by Ophthalmologist:

☐ N/A ☐ No ☐ Yes ☐ Pending ☐ See Medical Record for Report

Name of Ophthalmologist: _____

Photographs Taken By: _____

O. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ N/A ☐ Film Retained

☐ Film Released to: _____

Photographs taken by: _____

35mm ☐ Digital ☐ Instant ☐ Other ☐ _____

Recommend follow-up photographs be taken in 1-2 days

☐ No ☐ Yes ☐ N/A

Patient Identification: **Date:**

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Describe:

☐ Neglect
☐ Physical abuse
☐ Evaluation suspicious for physical abuse. Further information needed.
☐ Indeterminate cause
☐ Evaluation indicates non-abusive cause of medical findings.

☐ See Additional Dictation Dictation Reference Number:

Q. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit) ☐ N/A	
Evidence Kit ☐ N/A	
Reference samples ☐ N/A	
Toxicology samples ☐ N/A	

R. PERSONNEL INVOLVED

Examination Performed By: (Print)	Signature of Examiner	
License No.	Telephone	Date
Examination Assisted By: (Print)	Signature	
License No.	Telephone	Date
Specimen labeled and sealed by:	Signature	
License No.	Telephone	Date

S. PATIENT DISPOSITION

☐ Admitted ☐ Home ☐ Protective Custody

☐ Follow Up Exam Needed (specify reason): _____

State of California
California Emergency Management Agency

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalEMA 2-900 INSTRUCTIONS

For more information or assistance in completing the CalEMA 2-900, please contact University of California, Davis California Clinical Forensic Medical Training Center at: (888) 705-4141 or www.ccfmtc.org

Available at**:** **www.calema.ca.gov**

CalEMA 2-900
Medical Report: Suspected Child Physical Abuse and Neglect Examination

REQUIRED USE OF STANDARD STATE FORM:
Penal Code § 11171 established the use of a standard form to record findings from examinations performed for suspected child physical abuse and neglect. This form is intended to facilitate identification of child physical abuse and neglect, and as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

CalEMA 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18
CalEMA 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual assault** (>72 hours) • Examination of children and adolescents under age 18
CalEMA 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abus Examination** • History of **acute sexual assault or assault** (<72 hours) • Examination of children and adolescents under age 18

INSTRUCTIONS FOR CalEMA 2-900
These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code § 11171 for performing examinations. Consult the California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect published by CalEMA for additional information including the knowledge, skills, and abilities necessary for health practitioners to complete the medical examination.

LIABILITY AND RELEASE OF INFORMATION
This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code§ 11164 or privilege), the Medical Information Act (Civil Code § 58 et seq.), the Physician-Patient Privilege (Evidence Code § 990), the Official Information Privilege (Evidence Code § 1040) and Penal Code § 11171.2. It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Print legibly. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information; or, for facilities to write in an identification number and date.

A. GENERAL INFORMATION
Note: If the facility patient label or registration face sheet includes the information requested in items #1-5 below, these may be used in lieu of handwritten entries. Mark the box and attach the label or registration face sheet to this form.

1. **Enter the name and address of the facility where the examination was performed.**
2. **Enter the date and time of the exam.**
3. **Enter the patient's name and telephone number.**
4. **Enter the patient's street address, city, county, state, and zip code.**
5. **Enter the patient's age, date of birth (DOB), gender, and ethnicity.**
6. **Enter whether an interpreter was used, the language used, and who provided interpreting services.**
7. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
8. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
9. **Enter the name(s) of siblings, gender, age, and date of birth.**

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT: Suspected Child Abuse and Neglect Form Department of Justice (DOJ) SS 8572.

1. **Penal Code § 11166 requires all professional medical personnel to report suspected child abuse and neglect, defined by Penal Code § 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to a local law enforcement agency OR a child protective services agency.**
2. **The CalEMA 2-900 should not replace the DOJ SS 8572 Suspected Child Abuse and Neglect Report. The SS 8572 is used by all mandated reporters to report suspected child abuse and neglect. The CalEMA 2-900 is used by medical personnel to document physical findings and is part of the medical treatment record (Penal Code § 11171.2(d).**
   - Check the appropriate box to indicate that a telephone report was made to a law enforcement agency and/or Child Protective Services. Identify the person who took the report, his/her telephone number, and the date the report was made.
   - Check the appropriate box to indicate whether the written report was submitted to a law enforcement agency or to Child Protective Services.
3. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

1. **Record name(s) of responding personnel from a law enforcement or child protective services agency and identifying information.**
2. **If unknown, check box.**

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION

1. **See page 2 for information on consent and authorization for examinations.**
2. **Authorization by law enforcement or child protective services is not required for healthcare providers to use this form. Authorization, however, may be required if either agency is the designated payor.**
3. **Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**
4. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

E. DISTRIBUTION OF CalEMA 2-900
Check boxes to indicate the distribution of the form.

F. PATIENT HISTORY

1. **Record the name(s) of the person(s) providing the history and their relationship to the patient.**
2. **Record the name(s) of the person(s) accompanying the child to the facility and their relationship to the patient.**
3. **Record the history of present illness.**
   - If dictating, provide brief 2-3 sentence handwritten summary.
   - Include date, time or timeframe of incident, place of incident, and the name, if known, of the initial reporting party.
   - If documenting specific statements made by the patient or historian, use quotation marks.
   - Document if statement(s) made by patient were spontaneous (i.e. not in response to a question or comment).
   - When interviewing verbal children, ask open-ended questions such as "What happened to you? Tell me what happened to you. How did this happen? What did he do or what did she do?" These are the easiest questions for children to answer. Avoid WHY questions or questions that require understanding abstract or complex concepts.
   - If there is an alleged accident, include details of the event. Ask where it happened, who witnessed the event, and how it happened. For example, if there is an alleged fall, ask the height of the fall and onto what surface.
   - Patient statements not heard directly by the recorder may be included, e.g. the child told his teacher that he was hit by a belt.
   - Document chronology of events leading up to medical presentation.

G. PAST MEDICAL HISTORY

1. **Record past medical history, if known.**
2. **Record past abuse history, history of exposure to domestic violence, if known.**
3. **Record history of exposure to prenatal and postnatal alcohol and drug exposure, if known.**
4. **Obtain urine toxicology according to hospital protocol or follow local policy established by criminal justice and child protection agencies under the circumstances described below.**
   - There is a reported history of child's removal from a drug manufacturing home, living in a home with significant drug exposure, or a request by law enforcement or CPS.
   - The child's clinical presentation is concerning and drug ingestion is suspected.
   - Some drugs may be detected in the urine up to 96 hours after ingestion. Collect urine in a clean container. It is important to collect the first available sample.
5. **Record any cognitive, developmental, physical, or mental/emotional disabilities.**
6. **Record whether growth and development is within normal limits. Check WNL, if within normal limits, ABN, if abnormal, or unknown.**
7. **Indicate whether there are any other pertinent medical conditions, particularly if any conditions may affect the interpretation of findings (e.g. bleeding disorders, bone diseases, etc).**

H. REVIEW OF SYSTEMS

Check the box "Negative except as noted below" if there are no identified medical problems. Describe, if signs and symptoms are present. Check the box if there is additional dictation in medical progress notes or another format.

I. NAME OF PERSON TAKING HISTORY

Print the name of the person taking the history, sign, date, and provide telephone number.

PATIENT CONSENT AND AUTHORIZATION FOR EXAM

Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g. law enforcement agency or county child protective services agency) in order to perform the examination. Follow local policy regarding placement of children in protective custody.

Welfare and Institutions Code Section 324.5

Whenever allegations of physical or sexual abuse of a child come to the attention of a local law enforcement agency or the local child welfare department and the child is taken into protective custody, the local law enforcement agency or child welfare department may, as soon as practically possible, consult with a medical practitioner, who has specialized training in detecting and treating child abuse injuries and neglect, to determine whether a physical examination of the child is appropriate. If deemed appropriate, the local law enforcement agency, or the child welfare department, shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and whenever possible, shall ensure that this examination takes place within 72 hours of the time the child was taken into protective custody. In the event the allegations are made while the child is in custody, the physical examination shall be performed within 72 hours of the time the allegations were made.

PHOTOGRAPHS OF INJURIES

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents, and by their direction, may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child victim the costs incurred by the county for the x-ray. No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

J. GENERAL PHYSICAL EXAMINATION

1. Record vital signs.

2. Record height in either centimeters or inches and weight in either kilograms or pounds. Indicate percentiles, if growth charts are available. For children under age 2, record head circumference and percentile.

3. Describe the patient's general physical appearance.
- Describe the patient's general demeanor including level of discomfort and pain.
- Provide brief handwritten summary, even if dictating. Check box if there is additional dictation in progress notes.
- Documentation helps the examiner recall the patient's behavior and response during the exam for future reference.

4. Record results of physical examination.
- Record all findings and whether the general exam was within normal limits (WNL).
- Describe abnormal findings (ABN).

> **Physical Findings:** A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials.

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, bites, and burns.
- Note areas of tenderness, deformity, or induration.
- Record size and appearance of injuries and other findings using the diagrams. Describe shape, size, and color of bruises or other cutaneous injuries.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

5. If genital injuries are sustained, use copies of page(s) 6 and 7 from the CalEMA 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form to document findings; <u>or</u> use that form to document all findings, if the history indicates that the patient has been sexually and physically abused.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams A and B.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams C and D.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. EXAMINATION OF THE HEAD, NECK, AND MOUTH

7. Examine the face, head, ears, hair, scalp, and neck for injury.

- Record injuries and other findings using the Diagrams E, F, G, and H.
- Examine mouth for injury and for missing or chipped teeth, or neglect of oral health.
  - > Signs and symptoms of dentofacial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
  - > Signs and symptoms of dental neglect may include: untreated rampant cavities, untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
- For head trauma cases:
  - > Examine head closely for evidence of scalp trauma. Record any bruises, areas of scalp swelling, or hair loss.
  - > In infants, note fullness or bulging of the anterior fontanelle or splitting of the sutures.
  - > Examine earlobes carefully for any bruising or petechiae. Record injuries using the diagrams.

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LABORATORY

All swabs and slides must be air dried prior to packaging (Penal Code § 13823.11). Air dry in a stream of cool air for 60 minutes. Place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10 percent bleach before each use.
Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. All containers must be labeled and sealed. Record all evidence transfers, also known as the chain of custody.

1. **Record whether clothing was collected, the items collected, and whether they were placed in an evidence kit or a paper bag. If not, check N/A.**
   - Collect outer and under clothing, if applicable. Coordinate with the law enforcement officer or child protective services worker regarding clothing to be collected. Clothing with bloodstains, tears, and burn holes can be related to physical abuse. Soiled, unkempt clothing can be related to neglect.
   - Wear gloves while collecting clothing. Have the patient disrobe on two large sheets of paper, placed one on top of the other, on the floor. Remove child's shoes before stepping on to the paper. Package each garment in an individual paper bag, label, and seal. Wet stains or garments require special handling. Consult local policy.
2. **Record all foreign materials collected and the name of the person who collected them. If none were collected, check N/A. Foreign materials (soil, vegetation) should be placed in bindles and/or envelopes. Use a separate bindle or envelope for materials collected from different locations. Label and seal.**
3. **Record whether saliva swabs from bite marks were obtained. Record whether a control swab was obtained from an unbitten atraumatic area. Swabs must be labeled with the patient's name and sample source.**

L. TOXICOLOGY SAMPLES

Record whether a urine toxicology sample was obtained. Up to 96 hours after suspected ingestion of drugs, collect a urine specimen in a clean container. It is important to collect the first available sample.

M. REFERENCE SAMPLES

1. **Record whether a DNA reference sample was collected.**
   - Policies pertaining to the collection of reference samples at the time of exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. A buccal (inner cheek) swab is less invasive and may be easier to obtain than a blood sample via venipuncture. Consult your local crime laboratory.
2. **Buccal swabs**
   - Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. Air dry, package, label, and seal.
3. **Blood**
   - Collect blood sample in lavender stoppered evacuated vial. A blood card is optional in some jurisdictions. Label the vial, place into an envelope, and seal.

N. DIAGNOSTIC STUDIES

1. **Record the types of laboratory work ordered, results, if known, and whether results are pending.**

CBC	Complete Blood Count
INR	International Normalized Ratio
PTT	Partial Thromboplastin Time
PT	Prothrombin Time
SGOT/SGPT	Liver Enzymes

2. **Record diagnostic imaging studies ordered, results, if known, and whether results are pending.**

Skeletal Survey	Series of radiographic images which encompass the entire skeleton
CT Scan	Computed Tomography Imaging
MRI	Magnetic Resonance Imaging

3. **Record whether patient was referred for evaluation by an ophthalmologist.**

O. PHOTO DOCUMENTATION

Record whether photographs were taken, type of camera used, and whether film was retained or released to a law enforcement agency.

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Provide interpretation and medical impression of history, examination, and diagnostic studies. Findings and interpretations are based on both the patient history available and the medical examination. Check the box if there is additional dictation in medical progress notes or another format and record dictation reference number.

Q. DISTRIBUTION OF EVIDENCE

List to whom the evidence was released. Check N/A if not applicable.

R. PERSONNEL INVOLVED

1. **Document who performed the examination by printing the examiner's name. The examiner must sign, date, and provide license and telephone number.**
2. **Document whether another healthcare provider assisted with the examination or evidence collection and handling. If so, print name, sign, date, and provide license and telephone number.**

S. PATIENT DISPOSITION

Indicate disposition and whether a follow-up exam is needed.